Attachment J.—State Quality Strategy

State of Kansas

KanCare Program

Medicaid State Quality Strategy

November 2011

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I. Introduction:

A. Background and Goals of Managed Care Program

The KanCare program is a managed care Medicaid program which will serve the State of Kansas through a coordinated approach. In 2010, Governor Sam Brownback identified the need to fundamentally reform the Kansas Medicaid program to control costs and improve the quality of services. The State of Kansas has determined that contracting with multiple managed care organizations (MCOs/CONTRACTOR(S)) will result in the provision of efficient and effective health care services to the populations currently covered by the Medicaid, Children's Health Insurance Program (CHIP), and substance use disorder (SUD) programs in Kansas, and will ensure coordination of care and integration of physical and behavioral health services with each other and with home and community based services (HCBS).

The Kansas Medicaid population is divided into three distinct populations – pregnant women and children, various disability groups (e.g., those with intellectual or physical disabilities, or both, and persons with severe and persistent mental illness – (SPMI)), and the aged (65 and older). The pregnant women and children (low-income populations) have been served in a capitated risk-based managed care program called HealthWave—which coordinated care for both Medicaid and CHIP Members. Roughly 238,000 were in this population in 2011. HealthWave services were provided through two MCOs. Another 75,000 individuals comprise the disabled population in Medicaid and about 30,000 are in the aged population.

Kansas Medicaid services are managed across three different State agencies. The Kansas Department of Health and Environment (KDHE) is the single State Medicaid agency (SSMA) and its Division of Health Care Finance (DHCF) is responsible for the Medicaid State Plan (SP), interactions with CMS, drawing down Federal financial participation (FFP) funds, and managing physical health care and behavioral health for children served in the CHIP. KDHE/DHCF also formulates eligibility policy and manages the Eligibility Clearinghouse, where the majority of the HealthWave eligibility determinations are made.

The Kansas Department on Aging (KDOA) provides policy decisions and day-to-day management of targeted case management (TCM) and HCBS for frail elders (FE), nursing facilities (NF), and the Program for All-Inclusive Care for the Elderly (PACE).

The Kansas Department of Social and Rehabilitation Services (SRS) manages behavioral health care for the non-CHIP populations and also administers six of the seven HCBS waivers the State has been granted. In addition, SRS field workers make eligibility determinations for the aged and disabled populations. Behavioral health services are currently provided to the Medicaid populations through a pre-paid ambulatory health plan (PAHP) including the 1915 (c) HCBS Waiver for Serious Emotional Disturbance and the Psychiatric Residential Treatment Facility (PRTF) Community Based Alternatives (CBA) Demonstration Grant. The non-Medicaid populations access mental health (MH) supports through a state grant to 27 Community Mental Health Centers (CMHCs). SRS field staff Members oversee the regulatory compliance of the CMHCs for the non-Medicaid population. Substance use disorder (SUD) services are provided through a pre-paid inpatient plan (PIHP). Multiple State and Federal funds for SUD and Problem Gambling services (Substance Abuse Prevention and Treatment Block Grant (SAPT BG) and associated State funds, Driving Under the Influence (DUI) and Problem Gambling) are also managed through that contract.

Non-emergency medical transportation (NEMT) is provided, for the current fee-for-service population, by a transportation broker through a risk-based capitated contract. In the current HealthWave program MCOs provide transportation.

HCBS are currently provided through seven 1915(c) waivers, targeting these specific populations:

- Children with autism

- Children and adults with developmental disabilities (DD)
- People ages 16 – 64 with physical disabilities (PD)
- Medically fragile children age 0-22 dependent on intensive medical technology (TA)
- People ages 16 – 64 with traumatic brain injuries (TBI)
- People 65 and older who are functionally eligible for nursing facilities (FE)
- Children who are seriously emotionally disturbed (SED).

A variety of community-based organizations (CBOs) currently provide services to HCBS populations, including, but not limited to:

- Area Agencies on Aging (AAA),
- Centers for Independent Living (CIL),
- Community Developmental Disability Organizations (CDDO),
- Community Service Providers (CSP),
- Community Mental Health Centers (CMHC), and
- Home Health Agencies (HHA).

In addition, most of the populations served through HCBS waivers also receive TCM through the SP. TCM is provided through the CBOs listed above or through other agencies or individuals affiliated with CBOs.

The populations served by HCBS waivers, along with others who are aged or disabled, receive their physical health care services in an unmanaged, FFS environment. One of the primary aims of this Request for Proposals (RFP) is to improve integration and coordination of care for this group which contains individuals with multiple chronic conditions. While managing several populations and programs allows for administrative efficiencies, the Kansas CONTRACTOR(S) are required to report separately on expenditures and utilization for behavioral health, physical health, long term care (LTC) and HCBS.

Purpose of Managed Care CONTRACT

Lieutenant Governor Colyer outlined eight (8) primary goals for the Medicaid Reform Initiative. These goals were:

1. Improvement of quality of care and services;
2. Integration and coordination of care for a holistic, population-based approach;
3. Encouragement and elimination of disincentives for the disabled to work without losing health coverage;
4. Emphasis on Medicaid as a short-term option for coverage;
5. Expectation of personal responsibility for active participation in health care maintenance;
6. Elimination of silos between population groups and providers;
7. Expectation of accountability for outcomes; and
8. Achievement of significant savings.

In light of these goals, Kansas Medicaid CONTRACTOR(S) will be required to provide quality care that includes, but is not limited to:

- Providing adequate capacity and service to ensure Member's timely access to appropriate needs, services and care;
- Ensuring coordination and continuity of care;
- Ensuring Members receive the services they need to maintain their highest functional level;
- Ensuring that Members' rights are upheld and services are provided in a manner that is sensitive to the cultural needs of Members, pursuant to Section 2.2.5 of the RFP;
- Encouraging Members to participate in decisions regarding their care and educating them on the importance of doing so;
- Placing emphasis on health promotion and prevention as well as early diagnosis, treatment and health maintenance;
- Ensuring appropriate utilization of medically necessary services; and
- Ensuring a continuous approach to quality improvement.

B. Performance Objectives

The State Quality Strategy aims to address the first goal of the Medicaid Reform Initiative: Improving quality of care and services. Specifically, the State has identified a number of explicit outcomes that will be worked toward through the comprehensive managed care CONTRACT(s). These outcomes include the following:

- Measurably improve health care outcomes for Members in the following areas:
  - Diabetes
  - Coronary Artery Disease
  - Chronic Obstructive Pulmonary Disease
  - Prenatal Care
  - Behavioral Health;
- Improve coordination and integration of physical health care with behavioral health care;
- Support Members successfully in their communities;
- Promote wellness and healthy lifestyles; and
- Lower the overall cost of health care.

The CONTRACTOR(S) shall provide for the delivery of quality care that is: (1) accessible and efficient; (2) provided in the appropriate setting; (3) provided according to professionally accepted standards; and (4) provided in a coordinated and continuous manner. The goal of the quality management process (also known as Quality Assessment and Performance Improvement (QAPI)) is to assess, monitor, and measure for improvement of the health care services provided to Members served by the CONTRACTOR(S). The CONTRACTOR(S) shall be held accountable for the quality of care delivered by providers and subcontractor(s). This includes ensuring that a process is in place to monitor services provided in home and community-based settings. The CONTRACTOR(S) shall ensure quality medical care is provided to Members, regardless of payer source or eligibility category.

Inherent in achieving these goals is the development of a process through which the State and the CONTRACTOR(S) can collaborate to establish objectives and timetables for improvements of health care service and delivery.

Performance Measures
Given the above-stated goals of the KanCare program, performance measures were selected to provide evidence of the overall quality of care and specific services provided to each KanCare population group. CONTRACTOR(S) shall report the performance measures listed in Appendices 1-11 to the State in the time and format specified. The CONTRACTOR will be expected to meet or exceed designated benchmarks for specific performance measures. The performance measures are only one form of performance requirements for the CONTRACTOR(S). All CONTRACTORS shall comply with all State and Federal Waiver requirements regardless of whether or not there is a specific performance measure related to the requirement.

Definitions
For definitions of the words and terms used in this Quality Strategy, refer to Kansas Administrative Regulation 30-5-58 and Attachment C.

II. Assessment

A. Quality and Appropriateness of Care

1. How information on the race, ethnicity, and primary language spoken for each enrollee is collected and transmitted to managed care plans

At the time of application into the Kansas Medicaid program, Members are given the opportunity to indicate their race, ethnicity and primary language. By Federal law these are voluntary fields included in the application, but the information is collected when provided. This information is received from the Kansas Medicaid eligibility system and passed to the Medicaid Management Information System (MMIS) system using Health Insurance Portability and Accountability Act (HIPAA) standards. This information is collected into an 834 transaction field and is indicated in the race field (DMG05) and the primary language field (LUI02) and is then passed to the CONTRACTOR(S) electronically via the enrollment roster at the time of enrollment in the CONTRACTOR.

In section 2.2.17.1.1, the CONTRACTOR(S) are required to provide written information in Spanish, which is the Kansas' designated prevalent non-English language. The CONTRACTOR(S) must also provide oral interpretation services free of charge to each Member. This applies to all non-English languages, not only prevalent non-English languages. The CONTRACTOR(S) shall notify Members that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services. The CONTRACTOR(S) shall have means available to communicate with the Member in his/her spoken language, and/or access to a phone-based translation service so that someone is readily available to communicate orally with the Member in his/her spoken language.

2. Use of External Quality Review Organization (EQRO) Technical Report to evaluate quality and appropriateness of care

An External Quality Review (EQR) of the CONTRACTOR(S) will be conducted annually related to quality outcomes, timeliness of and access to the services covered under each CONTRACT. The EQR is conducted consistent with the Centers for Medicare and Medicaid Services (CMS) protocols. The EQR is a technical report regarding three (3) mandatory activities and several optional activities required by the State. The report must include the following information:

- The manner in which the data was aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the CONTRACTOR(S);
- An assessment of the CONTRACTOR's strengths and weaknesses with respect to quality, timeliness, and access to health care services;
- Recommendations for improving the quality of health care services; and
- An assessment of the degree to which the CONTRACTOR implemented the previous year's EQR recommendations for quality improvement and the effectiveness of the recommendations.

The EQR consists of the following mandatory activities:

- Validation of at least two (2) performance improvement projects (PIPs) required by the State to comply with requirements set forth in 42 CFR §438.240(b)(1), that were underway during the preceding 12 months. Some performance measures may be required by the State to be continued, based on specific outcomes for a specified period of time. The State reserves the right to require additional performance improvement projects if they are deemed necessary.
- Validation of CONTRACTOR performance measures reported (as required by the State) or CONTRACTOR performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in 42 CFR §438.240(b)(2).
- A review, conducted within the first year of this CONTRACT, and at least every three (3) years thereafter, to determine the CONTRACTOR's compliance with standards (except with respect to standards under 42 CFR §438.240(b)(1) and (2), for conducting performance improvement projects and calculations of performance measures, respectively) established by the State to comply with the requirements of 42 CFR §438.204(g).

For each activity, the report must specify the objectives, technical methods of data collections and analysis, a description of data obtained, and any conclusions drawn from the data. The EQR may also consist of optional activities as determined by the State.

Independent EQRs and activities are a primary means of assessing the quality, timeliness and accessibility of services provided by Medicaid CONTRACTORs. The EQRO annual technical report compiles the results of these reviews and activities, making it a streamlined source of unbiased, actionable data. The State can use this data to measure progress toward stated goals and objectives and to determine if new or restated goals are necessary.

Where applicable, the data in the annual technical report shall be trended over time to help the State identify areas where targeted quality improvement interventions might be needed. As mandated by 42 CFR § 438.364, technical report data make it possible to benchmark performance both statewide and nationally.

3. Clinical Standards and Guidelines

Provision of Services

Each CONTRACTOR must develop and/or adopt practice guidelines as described in 42 CFR 438.236. The CONTRACTOR must implement procedures that ensure the provision of medically necessary services as specified, subject to all terms, conditions and definitions of the CONTRACT. Any and all disputes relating to the definition and presence of medical necessity shall be resolved in favor of the State. Covered services shall be available statewide through the CONTRACTOR or its subcontractor(s). The CONTRACTOR shall maintain a benefit package and procedural coverage at least as comprehensive as the State Title XIX and Title XXI Plans. Experimental surgery and procedures are not covered under the State Title XIX and Title XXI Plans as described in Attachment F-- Services.

The CONTRACTOR must ensure that during the delivery of services that the services may not be arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition. Appropriate limits should be placed on a service based on criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. Medical services shall be provided in a manner as described by the SP and as Medically Necessary (defined in KAR 30-5-58 and Attachment C- Definitions and Acronyms). Each CONTRACTOR must identify, define, and specify the amount, duration, and scope of each service that the CONTRACTOR is required to offer. The CONTRACTOR may offer value added services beyond the requirements of the SP, but must specify the amount, duration and scope of these services. The State will ensure that the required services offered under the CONTRACT are in an amount, duration, and scope that is no less than that required for the same services furnished to Members under FFS Medicaid.

The CONTRACTOR shall have a process in place to assess the quality and appropriateness of care furnished to Members. Certain Members must have individually documented care coordination plans as defined in section 2.2.25 of the RFP. The CONTRACTOR shall update and modify the care coordination plan when a high risk Member experiences a change in their health status. Documentation of care coordination must be available to the State upon annual audit and at any other time the State requests such information. Each CONTRACTOR must provide for a second opinion, when requested from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the Member.

The CONTRACTOR shall adopt practice guidelines that rely on credible scientific evidence published in peer reviewed literature generally recognized by the medical community. To the extent applicable, the guidelines shall take into account physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and other relevant factors. At minimum, clinical practice

guidelines and best practice standards of care shall be adopted by the CONTRACTOR for the following conditions and services:

- Asthma;
- Congestive Heart Failure (CHF);
- Coronary Artery Disease (CAD);
- Chronic Obstructive Pulmonary Disease (COPD);
- Diabetes;
- Adult Preventive Care;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals age 0 to 20;
- Smoking Cessation for pregnant women;
- Behavioral Health (MH and SUD) screening, assessment, and treatment, including medication management and primary care provider (PCP) follow-up;
- Psychotropic medication management;
- Clinical Pharmacy Medication Review;
- Coordination of community support and services for Enrollees in HCBS Waivers;
- Dental services;
- Community reintegration and support; and
- LTC residential coordination of services.

The scope of the practice guidelines shall be comprehensive, addressing both quality of clinical care and the quality of non-clinical aspects of service, such as but not limited to: availability, accessibility, coordination and continuity of care.

B. CONTRACT Compliance of the CONTRACTORs

To ensure the goals of the RFP and Medicaid Reform Initiative are met, the State has established the following standards in the CONTRACTs for access to care, structure and operations, and quality measurement and improvement.

1. Access to Care

In addition to the access requirements set forth in Section 2.2.15 General Access Standards in the RFP, all services provided by the CONTRACTOR(S) must meet the criteria listed below for access.

24/7 Access to Services
Procedures must be in place to provide coverage, either directly or through its PCPs, to enrollees 24 hours per day, seven (7) days per week. The procedures shall include availability of 24 hours, 7 days per week access by telephone to a live voice (an employee of the CONTRACTOR or an answering service) which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems during non-office hours. **Recorded messages are not acceptable**. The management of incoming calls from Members must be clearly defined including equal access to all participants. Direct contact with qualified clinical staff must be available through a toll-free voice and telecommunication device for the deaf telephone number.

Network Provider Locations
Network providers including PCPs, pharmacies and hospitals shall be located in every county where Members reside. If no primary care physician, pharmacy or hospital is located in a given county, the CONTRACTOR shall ensure that services are provided to Members located within that county. The CONTRACTOR may include providers from other states in their provider network. Members may cross the state line for treatment, if they reside in a border city which is within 50 miles of the state

line. However, CONTRACTOR(S) is required to establish a preference for in-state providers when available at competitive rates and levels of quality. The CONTRACTOR, in establishing and maintaining its network of providers must consider the geographic location of providers and Medicaid Members, considering distance, travel time, the means of transportation ordinarily used by Medicaid Members, and whether the location provides physical access for Medicaid Members with disabilities.

Provider Hours of Operation
Network providers shall offer hours of operation that are no less than the hours of operation offered to commercial Members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid Members as specified in Section 2.2.7 of the RFP. The CONTRACTOR shall establish procedures to ensure that network providers comply with all timely access requirements and be able to provide documentation demonstrating the monitoring of this element. Corrective actions must be defined and utilized if a provider is found to be noncompliant within the scope of these procedures.

Network Provider Standards
Each CONTRACTOR must ensure that its providers and subcontractor(s) are credentialed and re-credentialed per National Committee for Quality Assurance (NCQA) guidelines as required in regulation and Section 2.2.8 of the RFP. Each CONTRACTOR must submit documentation to the State to demonstrate in a format specified by the State, that it:

- Offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of Members for the service area;
- Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area; and
- Requires its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services.

The CONTRACTOR, in establishing and maintaining its network of providers, must consider the following:

- The anticipated enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Title XIX – Medicaid and Title XXI populations represented in the CONTRACTOR enrollment population;
- The numbers and types (in terms of training, experience, and specialization) of providers required to provide the contracted services;
- The numbers of network providers who are not accepting new Title XIX – Medicaid and/or Title XXI.

The CONTRACTOR(S) shall maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the number of anticipated Members and shall document adequate capacity no less frequently than:

- at the time it enters into a CONTRACT with the State;
- at any time there is a significant change (as defined by the State) in the CONTRACTOR'S operation that would affect adequate capacity and services;
- if there are changes in services, benefits, geographic service areas; or
- if there are new populations enrolled with the CONTRACTOR.

The documentation of network adequacy shall be signed by the Chief Executive Officer (CEO) and submitted at least annually to the State.

Out-Of Network Providers
Members shall have access to Out-of-Network Providers when appropriate services are not available within the CONTRACTOR network. Each CONTRACTOR must require that if the network is unable to provide necessary medical services covered under the CONTRACT to a particular Member, the CONTRACTOR must adequately and timely cover these services out of network for as long as the CONTRACTOR network is unable to provide them. Each CONTRACTOR shall require out-of-network providers to coordinate with the CONTRACTOR with respect to payment. The

CONTRACTOR must ensure that cost to the Member is no greater than it would be if the services were furnished within the network.

Policies for Emergency Care and Prior Authorization (PA)
Written policies and procedures must be provided by the CONTRACTOR describing how Members and providers may contact the CONTRACTOR to receive individual instruction on accessing emergency and post stabilization care services or receive PA for treatment of an urgent medical problem and instruction when outside the State defined geographic area. Policies and procedures must be available in an accessible format upon request.

Service Authorization
The CONTRACTOR(S) and its subcontractor(s) must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services in accordance with 42 CFR 438.210.

Cultural Competence and Translation
Each CONTRACTOR must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The CONTRACTOR shall notify Members, applicants or potential applicants of the right to receive any documents translated and/or oral interpretation services at no cost. Translation services available must include; English, Spanish, French, German, Russian, Vietnamese, Arabic, Chinese, Korean, and Japanese languages. Additional languages may be required as updated state census data becomes available.

Primary Care Services
Each CONTRACTOR must implement procedures to ensure that each Member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the Member. The services the CONTRACTOR furnishes to the Member must be coordinated with the services the Member receives from any other managed care entity and the results of the CONTRACTOR's identification and assessment of any Member with special health care needs (as defined by the State) must be shared to avoid duplication of services. The CONTRACTOR(S) must ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 CFR §160 and 164.

When appropriate, the CONTRACTOR shall provide a health home (HH) for each Member as specified in Section 2.2.26 and Attachment I.

Women's Health Services
The CONTRACTOR shall provide female enrollees with direct access to a women's health specialist within the network for routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a woman's health specialist. Out-of-network providers shall be an option for the Member in the event a network provider is not available. Out-of-network providers must coordinate with the CONTRACTOR with respect to payment. The CONTRACTOR must ensure that cost to the Member is no greater than it would be if the services were furnished within the network.

2. Structure and Operations
Each CONTRACTOR shall provide documentation at the time of the annual audit or at any other time the State requests, information ensuring that participating providers have in place a process to meet the following requirements set forth 42 CFR 438.

a. Provider Selection
Service delivery by appropriately qualified individuals promotes patient safety and thus represents one essential structural component of a high quality delivery system. This standard ensures that

managed care entities implement written policies and procedures for the selection and retention of providers.

The CONTRACTOR(S) must comply with the requirements specified in 42 CFR 438.214, including

- selection and retention of providers,
- credentialing and recredentialing requirements, and
- nondiscrimination.

The State requires the plans to have written policies and procedures and a description of its policies and procedures for selection and retention of providers following the State's policy for credentialing and recredentialing as specified in 42 CFR 438.214(a), 42 CFR 438.214(b)(1), 42 CFR 438.214(b)(2), and Section 4.1.1.68.11.3 of the RFP. The CONTRACTOR must demonstrate that its providers are credentialed as specified in 42 CFR 438.206(b)(6), during the initial CONTRACT application process and during the annual on-site surveys and desk reviews. The provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment as specified in 42 CFR 438.214(c). The CONTRACTOR shall not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act as specified in 42 CFR 438.214(d).

b. Enrollee Information

Good communication enhances access to care, appropriate use of services, and satisfaction. This standard delineates requirements for communicating with enrollees and potential enrollees. Each managed care entity shall provide all enrollee notices, information materials and instructional material in a manner and format that may be easily understood, in accordance with 42 CFR 438.10 and Section 2.3.3 of the RFP. This includes ensuring capacity to meet the needs of non-English linguistic groups in their service areas and making available materials in alternative formats upon request. The State or its enrollment broker provides all enrollment notices, information materials and instructional material to enrollees and potential enrollees in a manner and format that may be easily understood, in accordance with 42 CFR 438.10.

On an annual basis, managed care entities must provide enrollees with notice of their right to request and obtain information on the various items required in 42 CFR 438.10(f). In addition, managed care entities must provide enrollees with 30-day prior written notification of any significant changes, including changes to enrollee cost sharing and benefits. Managed care entities must make a good faith effort to provide written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by the terminated provider.

c. Confidentiality

This standard requires that managed care entities and the State take appropriate steps to safeguard personal health information (PHI). For medical records and any other health and enrollment information that identifies a particular enrollee, the CONTRACTOR(S) shall establish and implement procedures consistent with confidentiality requirements in 45 CFR parts 160 and 164 Subparts A and E, 42 CFR 438.224 and 42 CFR Part 2. During the initial CONTRACT application process, the State will ensure the plans establish and implement procedures consistent with Federal and State regulations including confidentiality requirements in 45 CFR parts 160 and 164, 42 CFR 438.224 and 42 CFR Part 2. The State conducts annual on-site surveys and desk reviews to ensure the plans maintain procedures consistent with State and Federal regulations.

d. Enrollment and Disenrollment

The Kansas fiscal agent will specify procedures for enrollment and reenrollment. In accordance with 42 CFR 438.226, the CONTRACTOR shall demonstrate the following standards for enrollment and disenrollment through CONTRACT monitoring and document review:

1. No restriction of choice for providers or disenrollment limitation.

2. Demonstrate collection of data that specifies the rationale for disenrollment requests by both Members and providers.
3. Disenrollments do not occur because of a change in the Member's health status, because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the CONTRACTOR seriously impairs the entity's ability to furnish services to either this particular Member or other Members),
4. The methods by which the CONTRACTOR assures the State that it does not request disenrollment for reasons other than those permitted in the CONTRACT.
5. Acceptance of individual in the order in which they apply without restriction, up to the limits set under the CONTRACT.
6. Non discrimination against individuals eligible to enroll on the basis of:
    - Health status or need for health care services, discriminate against individuals eligible to enroll.
    - Race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

All CONTRACTs applicable to disenrollment and resulting action must specify the following as causes:

1. The plan does not, because of moral or religious objections, cover the service the Member seeks.
2. The Member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the Member's PCP or another provider determines that receiving the services separately would subject the Member to unnecessary risk.
3. Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the CONTRACT, or lack of access to providers experienced in dealing with the Member's health care needs.

Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the Member files the request. If the State fiscal agent fails to make the determination within the timeframes specified the disenrollment is considered approved. The CONTRACT must provide for automatic reenrollment of a Member who is disenrolled solely because he or she loses Medicaid eligibility for a period of two (2) months or less.

e. Grievance Systems

The CONTRACTOR(S) shall comply with all Grievances and Appeals provisions as specified in Attachment D—Grievances and Appeals. Such system must comply with the provisions of 42 CFR 438.400 – 438.424.

f. Subcontractor(s)

Managed care entities typically contract with many different providers and vendors of services to deliver the full package of services to enrollees. These standards ensure that the CONTRACTOR(S) are accountable for the actions and performance of any subcontractor. This assurance shall be met through the annual auditing process and will require the CONTRACTOR to produce documentation that supports the following:

1. The CONTRACTOR must evaluate the prospective subcontractor's ability to perform any delegated activities.
2. The CONTRACTOR and the subcontractor must specify in writing the activities and reports being delegated.
3. Failure of the subcontractor to perform in accordance to their contract with the CONTRACTOR may result in sanctions and/or revoking the contract.

4. The CONTRACTOR must monitor the subcontractor(s)' performance on an ongoing basis and subject it to a formal review in accordance to a periodic schedule established by the State, consistent with industry standard or regulated by State or Federal laws/regulations.
5. The CONTRACTOR must identify deficiencies or areas for improvement, the entity and the subcontractor must take corrective action.

All subcontractual relationships and delegations must be in accordance with 42 CFR 438.230.

3. Quality Measurement (QM) and Improvement

a. Practice Guidelines

The State requires that each CONTRACTOR adopt practice guidelines that meet the requirements of 42 CFR 438.236(b). The following requirements will be reviewed at annual audit and at any other time that the State requests. Practice guidelines shall

- be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- consider the needs of the enrollees;
- be adopted in consultation with contracting health care professionals; and
- be reviewed and updated periodically as appropriate.

The State requires that the CONTRACTOR(S) disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Decisions for utilization management (UM), Member education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines. These will be reviewed upon annual audit and at any other time that the State requests.

b. Quality Assessment and Performance Improvement (QAPI) Program

The CONTRACTOR shall have an ongoing QAPI program which assesses monitors, evaluates and improves the quality of care provided to Members. This program shall conform, as applicable, to all the requirements prescribed by CMS in 42 CFR 438, Subpart D, and include processes which provide for the evaluation of access to care, availability of services, continuity of care, health care outcomes, and services which are provided or arranged for Members by the CONTRACTOR(S). The QAPI program shall consist of internal monitoring by the CONTRACTOR(S), oversight by Federal and State governments, and evaluations by an EQRO. Areas found to be deficient during the above processes shall be addressed by the CONTRACTOR(S) through a Corrective Action Plan (CAP) process initiated internally or by the State as specified in RFP Section 2.3.4.2.

The QAPI program shall objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its Medicaid population. The CONTRACTOR's written policies and procedures must address components of effective health care management including but not limited to anticipation, identification, monitoring, measurement, evaluation of enrollee's health care needs, and effective action to promote quality of care.

The QAPI program shall include:

- Conducting PIPs described in 42 CFR 438.240 (d) and as specified by the State;
- Submitting performance measurement data described in 42 CFR 438.240 (c) and in this Attachment;
- Establishing mechanisms for detecting both underutilization and over utilization of services;
- Establishing mechanisms for assessing the quality and appropriateness of care furnished to Members, including those with special health care needs;
- Reporting on measures related to homelessness and employment; and
- Reporting all behavioral health, disabilities and physical health data in separate reports.

Additionally, as part of the QAPI program, the CONTRACTOR(S) are required to have programs and procedures in place to measures the quality and outcomes for nursing facilities. Each CONTRACTOR must submit a plan for oversight of nursing facilities, which shall be approved by the State on an annual basis.

Through the QAPI program, the CONTRACTOR(S) shall define and implement improvements in processes that enhance clinical efficiency and focus on improved outcome management achieving the highest level of success. Each CONTRACTOR and the CONTRACTOR'S quality improvement program is required to demonstrate how specific interventions better manage the care and impact healthier patient outcomes to achieve the goal of providing comprehensive, coordinated, high quality, accessible, cost effective, and efficient health care to Medicaid beneficiaries. Pursuant to 42 CFR 438.208(c)(1), the State requires the plans to implement mechanisms to identify persons with special health care needs, as those persons are defined by the State. CMS, in consultation with the State and other stakeholders, may specify performance measures and topics for PIPs.

The CONTRACTOR shall provide a written description of the QAPI program that identifies full-time staff specifically trained to handle the Medicaid business and delineates how staffing is organized to interact and resolve problems, define measures and expectations, and demonstrate the process for decision making (i.e. projects selection, interventions) and reevaluation. The CONTRACTOR(S) shall provide for quality improvement staff specifically trained to handle the Medicaid business which have the responsibility for identifying their Medicaid beneficiaries' needs and problems related to quality of care for covered health care and professional services, measuring how well these needs are met, and improving processes to meet these needs.

The QAPI program shall evaluate ways in which care is provided, identify outliers to specific indicators, determine what shall be accomplished, ascertain how to determine if a change is an improvement, and initiate interventions that will result in an improved quality of care for covered health care and professional services. Each CONTRACTOR is required to prioritize problem areas for resolution and design strategies for change as well as implement improvement activities and measure success.

The CONTRACTOR(S) shall cooperate with the State and the External Quality Review Organization (EQRO) vendor in developing its QAPI program. The State sets methodology and standards for QAPI performance improvement with advice from the EQRO. Prior to implementation, the State and/or the EQRO review each CONTRACTOR's QAPI program. Each CONTRACTOR's QAPI program must be approved, in writing, by the State no later than three (3) months following the effective date of the CONTRACT. If a CONTRACTOR has submitted and received approval for the present calendar year, an extension may be granted for the submission of new projects.

Each CONTRACTOR shall have a QAPI governing body. This body shall monitor, evaluate, and oversee results of the QAPI program to improve care. The governing body shall have written guidelines and standards defining their responsibilities for:

1. Supervision and maintenance of an active QAPI committee;
2. Ensuring ongoing QAPI activity coordination with other management activity, demonstrated through written, retrievable documentation from meetings or activities;
3. Planning, decisions, interventions, and assessment of results to demonstrate coordination of QAPI processes;
4. Oversight of QAPI program activities; and
5. A written diagram that demonstrates the QAPI system process.

The QAPI committee shall:

1. Direct and review quality improvement activities;
2. Assure that quality improvement activities take place throughout the plan;
3. Include a meaningful representation of stakeholders;

4. Review and suggest new or improved quality improvement activities;
5. Direct task forces/committees in the review of focused concern;
6. Designate evaluation and study design procedures;
7. Publicize findings to appropriate staff and departments within the plan;
8. Report findings and recommendations to the appropriate executive authority; and
9. Direct and analyze periodic reviews of Members' service utilization patterns.

For each year of the CONTRACT, the CONTRACTOR(S) shall comply with the QAPI Program standards established by the State as well as the NCQA standards/guidelines. The CONTRACTOR(S) shall monitor NCQA standards/guidelines and remain updated on any changes. The State reserves the right to revise established standards and their respective elements to ensure compliance with changes to Federal or State statutes, rules, and regulations as well as for clarification and to address identified needs for improvement.

Each CONTRACTOR will be required to annually review and evaluate the overall effectiveness of the QAPI program to determine if the program has demonstrated improvement in the quality of care and provision of services to Members. As necessary, the CONTRACTOR(S) may modify its QAPI program with the approval of the State. The CONTRACTOR(S) shall prepare a written report to the State, detailing the annual review which shall include a summary and review of completed and continuing quality improvement activities that address the quality of clinical care and services; trending and analysis of measures to assess performance in quality of clinical care and services; any corrective actions which are recommended, implemented, or in progress, as well as modifications made to the program. The CONTRACTOR(S) shall demonstrate that its quality improvement activities have contributed to improvement of the quality of clinical care and services, including but not limited to preventive health care provided to Members. The CONTRACTOR shall submit this report annually in a format specified by the State.

c. Performance Measures

The State requires the CONTRACTOR(S) to collect data on patient outcome performance measures, as defined by the Healthcare Effectiveness Data and Information Set (HEDIS) or otherwise defined by the State in Appendices 1-11 and to report the results of the measures to the State annually. The CONTRACTOR(S) shall submit data on the corresponding national and regional benchmarks when available as specified by the State. The State may add or remove reporting requirements with 30-days advance notice. The CONTRACTOR(S) shall comply with all QM requirements to improve performance on all established performance measures.

C. Impact of Health Information Technology

KDHE, the State designee for health information technology (HIT), is facilitating the creation of strategic and operational plans for a statewide infrastructure for health information exchange (HIE). These plans will act as a blueprint for not-for-profit organizations responsible for the deployment and operation of the Kansas health information exchange (KHIE). The primary goal of the KHIE is to enable health care stakeholders to share data for coordinating patient care and to support public entities in achieving their population health goals. More specifically, this process will assist in the development of health homes for Kansans. The implementation of managed care will support the current HIT/HIE efforts in Kansas through a number of CONTRACTOR requirements. Specifically, the following requirements are provided in Section 2.2.14 of the RFP.

The CONTRACTOR shall submit a plan to the State that details how it will use HIT to improve coordination and integration of care, promote prevention and wellness, and improve quality through appropriate sharing of clinical and administrative data among providers and to the State. This plan, at a minimum, will:

a. Specify how the CONTRACTOR will work within the framework outlined by the KHIE Board to facilitate electronic exchange of health information between providers and the CONTRACTOR, and between the CONTRACTOR and the State;
b. Demonstrate how the CONTRACTOR will work with providers to assist in their acquisition and use of certified electronic health record (EHR) technology in accordance with the Kansas Medicaid HIT Plan
(located at http://www.kdheks.gov/hcf/hite/download/Overview_Activities_HIT_HIE.pdf.) and
c. Demonstrate how the CONTRACTOR will accept and use data from certified EHR technology.

III. Improvement

State Strategies and Interventions for Quality Improvement

Based on the results of the assessment activities, quality of care delivered by the CONTRACTOR will be improved in a number ways. As results from assessment activities become available, the State may define additional improvement opportunities.

Performance Improvement Projects
Each CONTRACTOR will conduct PIPs that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction. The State will approve and provide input on the selected topics for all PIPs. The CONTRACTOR(S) must ensure that CMS protocols for PIPs are followed and that the following are documented for each activity:

- Rationale for selection as a quality improvement activity;
- Specific population targeted including sampling methodology if relevant;
- Metrics to determine meaningful improvement and baseline measurement;
- Specific interventions (Member and provider);
- Relevant clinical practice guidelines; and
- Date of re-measurement.

Each CONTRACTOR must submit new data on at least two (2) PIPs annually to the State. This does not mean two (2) new PIPs a year. PIPs must be submitted to and approved by the State prior to implementation. PIPs must include the following:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions;
- Planning and initiation of activities for increasing or sustaining improvement; and
- Reporting the status and results of each project to the State on an annual basis.

Each PIP must be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year. The CONTRACTOR(S) shall report the status and results of each project to the State and its designee as requested. The State reserves the right to require additional PIPs if it is deemed necessary to improve the performance of the CONTRACTOR(S).

The CONTRACTOR(S) shall identify HEDIS, National Outcome Measurement System (NOMS), CMS approved HCBS Waiver Performance Measures and other benchmarks identified by the State and set achievable performance goals for each of its PIPs. The CONTRACTOR(S) shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.

Accreditation

Kansas Medicaid CONTRACTOR(S) and subcontractor(s) are required to become accredited by the National Committee for Quality Assurance (NCQA) as defined by the State. NCQA is an independent, 501(c) (3) non-profit organization that assesses and scores CONTRACTOR performance in the areas of quality management and improvement, utilization management (UM), provider credentialing and recredentialing, and Members' rights and responsibilities. This process leaves only those CONTRACTORS demonstrating the highest quality of care and service to provide for enrollees. In conjunction with accreditation, CONTRACTORS are required to annually submit a full set of audited measures from HEDIS and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to NCQA. NCQA uses the results to reevaluate the organization's performance on specified HEDIS/CAHPS measures, and may change the organization's accreditation status based on the results.

A CONTRACTOR which holds current NCQA accreditation status shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report. The submission shall include scoring of each category, standard, and elements levels and recommendations, as presented via the NCQA Interactive Survey System (ISS): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations, and History to the State in accordance within timelines established by the State.

If a CONTRACTOR has not earned accreditation of its Medicaid product through the NCQA, the CONTRACTOR shall be required to obtain such accreditation within 18 months of the effective date of this CONTRACT.

Health Information System Initiatives
Each CONTRACTOR must maintain a Health Information System (HIS) that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to utilization, grievances and appeals and disenrollments for other than loss of Medicaid eligibility.

The HIS must

- Collect complete and accurate data on Members and providers regarding information and services furnished through encounter data,
- Ensure data is accurate and complete by
    - Verifying accuracy timeliness reported data.
    - Screening data for completeness, logic, and consistency; and
    - Collecting service information in standardized formats to the extent feasible and appropriate.
- Makes sure data is available to the State of Kansas and CMS.

Pay for Performance (P4P) Incentives
As discussed in previous sections of this quality strategy, the CONTRACTOR(S) will be required to report on all HEDIS, CAHPS, and other performance measures for specific populations as required in Appendices 1-12 of this Strategy.

Additionally, the State will implement a pay-for-performance (P4P) program. During the first CONTRACT year, six (6) operational performance measures have been selected to measure the CONTRACTOR(S)'s performance during implementation and the transition of Members to the KanCare program. To incentivize high performance in year one (1), three (3) percent of the total capitation payments will be held back for the purpose of incentive payments to CONTRACTORs meeting the higher levels of performance dictated in the P4P program. These performance standards require CONTRACTOR(S) to exceed the minimum performance standard required for CONTRACT compliance and incentivize the CONTRACTOR(S) to perform at a higher level in six areas determined by the State to be critical for successful integration of Members into the new program. The year one operational measures are listed in the table below, with the contractual requirements in the middle column, and the P4P incentive requirements in the right column.

Performance Measure	Required Contractual Standard	Standard Required to Receive Incentive Payment (Benchmark)
Timely claims processing	Section 2.2.39.2.1- 100% of clean claims are processed within 30 days 2.2.39.2.2-99 % of all no clean claims are processed within 60 days 2.2.39.2.3-100% of all claims are processed within 90 days	100% of all clean claims are processed within 20 days 99% of all non clean claims are processed within 45 days 100% of all claims are processed within 60 days
Encounter data submission	See Attachment K	Contractor meets all of the performance standards within 60 days from implementation date.
Credentialing process	Section 2.2.4.1.7- credentialing of providers shall be completed as follows: 90% in 30 days 100% in 45 days	 90% are completed in 20 days 100% are completed in 30 days
Grievances	(See Attachment D) 98 % of grievances are resolved within 30 days 100% of grievances are resolved within 60 days	98 % of grievances are resolved within 20 days 100% of grievances are resolved within 40 days
Appeals	(See Attachment D) The CONTRACTOR must send a letter to the member within five (5) business days acknowledging receipt of the appeal request.	Contractor sends an acknowledgement letter within 3 business days of receipt of the appeal request
Customer Service	Section 2.2.42.7 95% of all inquiries shall be resolved within two (2) business days of receipt 98% of all inquiries shall be resolved within five (5) business days 100% of all inquiries shall be resolved within 15 business days .	98% of all inquiries are resolved within 2 business days from receipt date 100% of all inquiries are resolved within 8 business days from receipt date

Each of the six (6) areas identified above (timely claims processing, encounter data submission, credentialing process, grievances, appeals, and customer service) will be weighted at .5% of the 3% capitation withhold. A CONTRACTOR failing to meet all the required standards for an incentive payment in a given area will not receive .5% of their capitation payments back for each area in which it fails to meet the benchmark standard in full or in part. For example, if a CONTRACTOR fails to meet all of the required benchmarks in grievances, appeals, and customer services will not receive back 1.5% of their capitation payments back.

For CONTRACT years two (2) and three (3), 15 measures have been selected by the State as pay for performance (P4P) indicators (Five (5) for physical health, five (5) for behavioral health, and five (5) for LTC). To incentivize high performance and quality health outcomes, 5% of each CONTRACTOR's total per-Member, per-month payments will be held back each year for the purpose of incentive payments in years two (2) and year (3). If the CONTRACTOR meets quality benchmarks

established by the State for each of the 15 selected P4P indicators, the CONTRACTOR will receive the 5% back in full.

The P4P indicators are listed below.

Physical Health:

- Comprehensive Diabetes Care
    - This measure is actually a composite HEDIS measure composed of 10 rates. To be considered compliant with this measure, the CONTRACTOR must meet or exceed the benchmark rate for HbA1c screening, and meet or exceed the benchmark for seven (7) of the remaining nine (9) Comprehensive Diabetes Care rates following all required HEDIS methodology
- Well-Child Visits in the First 15 Months of Life
    - The CONTRACTOR(S) shall meet or exceed the benchmark using HEDIS methodology and specifications.
- Preterm Births
    - CONTRACTOR(S) shall utilize Joint Commission National Quality Measures methodology and meet or exceed the State-defined benchmark.
- Annual Monitoring for Patients on Persistent Medications
    - The CONTRACTOR(S) shall meet or exceed the benchmark using HEDIS methodology and specifications.
- Follow-up after Hospitalization for Mental Illness
    - The CONTRACTOR(S) shall meet or exceed the benchmark using HEDIS methodology and specifications.

Behavioral Health, LTC and HCBS Waivers (for complete description and methodology please see Appendix 12 of this Attachment):

- Increased Competitive Employment: An increased number of people with developmental or physical disabilities, or with significant mental health treatment needs, will gain and maintain competitive employment.
- National Outcome Measures (NOMs):
    - The NOMs for people receiving Substance Use Disorder services will meet or exceed the benchmark in at least 4 of these 5 areas: Living Arrangements; Number of Arrests; Drug and Alcohol Use; Attendance at Self-Help Meetings; and Employment Status.
    - The NOMs for people with SPMI or SED receiving mental health services will meet or exceed the benchmark in at least 4 of these 5 areas: Adult Access to Services; Youth Access to Services; Homeless SPMI; Youth School Attendance; and Youth Living in a Family Home.
- Decreased Utilization of Inpatient Services: A decreased number of people with mental health treatment needs will utilize inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services.
- Improved Life Expectancy: The life expectancy for people with disabilities will improve.
- Increased Integration of Care: The rate of integration of physical, behavioral (both mental health and substance use disorder), long term care and HCBS waiver services will increase.

Long-Term Care (for complete description and methodology please see Appendix 12 of this Attachment):

- Nursing Facility Claim Denials: The MCO will meet or exceed the benchmark for denial of nursing facility claims.
- Fall Risk Management: The number of people at risk of falling (i.e., who had a fall, had problems with balance and walking, or were identified as at risk for a fall) will be seen by a practitioner and receive fall risk intervention.
- Decreased Hospital Admission After Nursing Facility Discharge: The percentage of members discharged from a nursing facility who had a hospital admission within 30 days will be decreased.

- Decreased Nursing Facility Days of Care: The number of nursing facility days used by eligible beneficiaries will be decreased.
- Increased use of PEAK (Promoting Excellent Alternatives in Kansas)-Certified Days of Care: The percentage of nursing facility days paid for services in PEAK-certified person centered care homes will be increased.

CONTRACTOR(S) shall follow the required HEDIS, NOMS, or State-defined methodology when calculating the P4P indicators in years two (2) and three (3). Each of the above 15 P4P indicators shall be externally validated by the EQRO. Each CONTRACTOR is required to collect performance data for all 15 of the P4P measures in CONTRACT year one (1) to serve as baseline data upon CONTRACTOR(S) will be expected to increase.

CONTRACTORS will be assessed with regard to acceptable performance on the P4P indicators. For performance to be considered acceptable, the CONTRACTOR must meet the respective performance standards for all 15 P4P measures. The criteria for performance standards in the second measurement year shall be as follows:

- Failure to Meet Performance Standard- Any CONTRACTOR which has performed below the national Medicaid 50th percentile as defined by the NCQA (or other national benchmarks, when applicable) for the measurement year or five (5) percentiles higher than the CONTRACTOR's Medicaid benchmark rate for Kansas from the previous measurement year, whichever is higher, shall be considered as failing to meet performance standards.
- Minimum Acceptable Performance- Any CONTRACTOR which has performed at or above the national Medicaid 50th percentile as defined by the NCQA (or other national benchmarks, when applicable) for the measurement year or five (5) percentiles higher than the CONTRACTOR's Medicaid benchmark rate for Kansas from the previous measurement year, whichever is higher, shall be considered to have accomplished acceptable performance. CONTRACTORs performing at or above the higher of these two (2) benchmarks for all of the 15 P4P measures will receive the 5% PMPM withholding back in full at the end of measurement year.

The State expects to achieve continuous improvement in its Medicaid and CHIP programs, and will establish escalating targets for each measure over the three (3) year period of this CONTRACT. CONTRACTOR(S) will be expected to accomplish a five (5) percentile improvement on each P4P indicator in CONTRACT years two and three. This requirement is designed to ensure that CONTRACTOR(S) work to continually work to improve their performance on all P4P indicators and other performance measures. If any CONTRACTOR fails to meet the five (5) percentile improvement standard in year two or three, 1/15th of the 5% PMPM withholding will be kept by the State for each P4P indicator for which the CONTRACTOR failed to meet the performance benchmark. Further, in year three, if a CONTRACTOR fails to meet the year two (2) performance benchmark for any one of the 15 performance measures, 2/15^{ths} of the 5% PMPM withholding will be kept by the State and not returned to the CONTRACTOR for each indicator where performance levels were not met. In the event of additional CONTRACT years, 3/15^{ths} would be kept for failure to meet the year two (2) benchmark in year four (4), or to meet the year three (3) benchmark in year five (5), and 4/15^{ths} would be kept for failure to meet the year two (2) benchmark in year (5).

The State reserves the right to assess and modify the P4P indicators and benchmarks after the first CONTRACT year. If optional years are added to the CONTRACT with a CONTRACTOR, the State expects to escalate expected levels of performance on the original levels and/or to add additional performance measures to the process. For each new indicator the performance target would be set at an initial level in the first year of its inclusion and this target would escalate each year until reaching an exemplary level. New indicators may replace a corresponding number of previous indicators in the calculation of performance incentives, maintaining a list of 15 for which performance payments are calculated. Sustained performance at the highest levels would be expected for the growing list of performance targets, including those selected by the State for replacement by new measures.

The State reserves the right to tie PIP requirements to P4P indicators where the CONTRACTOR has failed to meet the benchmark or improvement standard. CAPs may also be instituted by the State for less than acceptable performance by a CONTRACTOR on the P4P indicators.

CONTRACTOR Proposals for Additional P4P Indicators
CONTRACTOR(S) who believe they can exceed the acceptable benchmark standard will be provided an opportunity to create and present additional performance targets and appropriate incentives. The State desires to add P4P measures which focus on patient outcomes, health and functional status. The State is particularly interested in P4P measures which address smoking cessation and obesity rates. Any plan for additional P4P incentives must be submitted by the CONTRACTOR at the same time as the QAPI plan. The State reserves the right to accept, reject, or modify any additional incentive plan proposed by a CONTRACTOR.

The State recognizes that improvements in quality will require enhanced coordination of care and consumer engagement, and will entail cooperation and improved systems of care among providers. The State acknowledges the central role that providers will play in achieving improved outcomes and encourages CONTRACTOR(S) to enable providers to share in the modest financial rewards available under this program for high-performing CONTRACTORS. The State also encourages the adoption of innovative, evidence-based provider payment mechanisms that incorporate performance and quality initiatives. Additional performance measures proposed by any CONTRACTOR should strive to decrease the level of reporting and administrative burden on providers.

<u>Dually-Eligible Individuals</u>
The State recognizes that data for individuals who are dually eligible for Medicare and Medicaid can be difficult to obtain and could impact the rates for certain P4P indicators. If a CONTRACTOR foresees that it will be unable to obtain an accurate measurement for any P4P measure because of data issues in the dual population, that CONTRACTOR shall propose a replacement indicator(s) that shall be used for the dual population only and must be externally validated by an EQRO. The replacement indicator shall be proposed as soon as the plan deems the data for dually-eligible individuals will not be available. In the event that a replacement indicator is proposed by a CONTRACTOR, the State will work with the CONTRACTOR to establish acceptable performance benchmarks. The non-dual rate for each P4P indicator must still be calculated in addition to the dual-specific indicator(s). The State expects CONTRACTOR(S) to assist in preparing recommendations to CMS for shared savings relative to serving Medicare-Medicaid dually eligible Members.

Quality Assessment and Performance Improvement (QAPI) Program Review
The State will annually review the impact and effectiveness of each CONTRACTOR(S)'s QAPI programs. The review must include but is not limited to performance on the standard required measures and the results of each PIP. The review will serve to pinpoint areas where quality and access can be improved. Additionally, each CONTRACTOR must have in effect a process for its own evaluation of the impact and effectiveness of its QAPI program.

CONTRACTOR Sanctions
To ensure quality of care and services, the State may impose sanctions upon the CONTRACTOR(S) for certain actions if the actions are confirmed by on onsite surveys, Member or other complaints, changes in financial status or any other source.

The following results may result in sanctions upon the CONTRACTOR(S).

- Failing substantially to provide medically necessary services that the CONTRACTOR is required to provide, under law or under its CONTRACT with the State, to a Member covered under the CONTRACT;
- Imposing premiums or charges on Members in excess of permitted charges;
- Acting to discriminate among Members on the basis of their health status or need for health care services;
- Misrepresenting or falsifying information that it furnishes to CMS or to the State.

- Misrepresenting or falsifying information that it furnishes to a Member, potential Member, or health care provider;
- Failing to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR §422.208 and 422.210;
- Failing to obtain minimum acceptable performance levels on any performance measure specified in Appendix 1-11 of this Strategy;
- Distributing directly, or indirectly through any agent or independent CONTRACTOR, marketing materials that have not been approved by the State or that contain false or materially misleading information; and
- Violating any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

Intermediate Sanctions that may be imposed include civil monetary sanctions, suspension of all new enrollment, including default enrollment, after the effective date of the sanction, and termination of the CONTRACT for failure to carry out the substantive terms of this CONTRACT or to meet applicable requirements in section 1932, 1903(m) and 1905(t) of the Act.

III. Review of Quality Strategy

A. Timeline Planned for Frequency of Strategy Assessments

In the effort to achieve safe, effective, patient-centered, timely and equitable care the State will assess the quality strategy on an annual basis and revise the State Quality Strategy document accordingly.

B. Timeline Planned for Reporting Strategy Updates to CMS

In the event that revisions need to be made to the State Quality Strategy, the State will document these changes and report these revisions to CMS for review when significant changes have been applied to the Strategy document.

C. Strategy Effectiveness

As the Quality Strategy evolves, challenges and successes that result in changes to the strategy will be documented through reviews and reports for each strategy objective.

Appendix 1. Performance Measures: Physical Health

Indicator LD=Liquidated Damages if not submitted	Reporting Frequency	Methodology	Benchmark Objective
All applicable Medicaid HEDIS measures calculated and submitted	Annually	HEDIS	Rates for each measure shall be at or above the national 50th percentile for Medicaid plans, or at or above the historical Kansas FFS rates—whichever is higher.
Preterm Births	Annually	Joint Commission National Quality Measures (see http://manual.jointcommission.org/releases/TJC2010B/MIF0166.html)	The rate of preterm births among Members shall be no more than 12% in year 1.
CAHPS Adult Survey CAHPS Child Survey CAHPS Children with Chronic Conditions	Annually	HEDIS/AHRQ	Survey completed by date set by the State. Plans must meet or exceed 2012 National average for each item as reported in the National CAHPS Benchmarking Database.
Total Eligibles who received preventive dental services	Annually	EPSDT	Plans must meet or exceed participation levels as reported in the 2010 CMS Form 416
Total Eligibles who received dental treatment services	Annually	EPSDT	Plans must meet or exceed participation levels as reported in the 2010 CMS Form 416
Prevention Quality Indicators • Diabetes short-term complication admission rate • Diabetes long-term complication admission rate • COPD or asthma in older adults admission rate • Hypertension admission rate • CHF admission rate • Dehydration admission rate • Bacterial pneumonia admission rate • Urinary tract infection admission rate • Angina without procedure admission rate • Uncontrolled diabetes admission rate • Asthma in younger adults admission rate • Lower extremity amputation rate among patients with diabetes	Annually	AHRQ (Please refer to http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx)	Measures are optional, but can be submitted by CONTRACTOR(S) to provide additional information to beneficiaries about the quality of services provided by the CONTRACTOR(S).

• Angina without procedure admission rate • Perforated appendix admission rate • Low birth weight rate			

Appendix 2. Performance Measures: Mental Health

Indicator	Proposed measurement	Numerator and denominator	Data source for measuring	Frequency of measuring
Mental Health Quality of Life Indicators	Percentage of Members reporting their physical health as good within one standard deviation of the mean. The indicator is measured by regions as established by the CONTRACTOR as approved by SRS.	Numerator: Number of Members reporting they are in good physical health Denominator: total number of persons interviewed.	Member Data to be gathered by the CONTRACTOR phone interviews with Members	The phone survey universe is derived from a random sample of active mental health consumers in the established region.
Mental Health Quality of Life Indicators	The Percentage of Members reporting they are connected to the people who support them the most within one standard deviation of the mean. The indicator is measured by regions as established by the CONTRACTOR as approved by SRS.	Numerator: Number of Members reporting connectivity to people who support them the most Denominator: total number of persons interviewed.	Member Data to be gathered by the CONTRACTOR phone interviews with Members	The phone survey universe is derived from a random sample of active mental health consumers in the established region.
Mental Health Quality of Life Indicators	The Percentage of Members reporting they are doing what they want for their work within one standard deviation of the mean. The indicator is measured by regions as established by the CONTRACTOR as approved by SRS.	Numerator: Number of adults with an SPMI who report doing what they want for work. Denominator: total number of persons interviewed.	Member Data to be gathered by the CONTRACTOR phone interviews with Members	The phone survey universe is derived from a random sample of active mental health consumers in the established region.
Mental Health Quality of Life Indicators	Percentage of adults with an SPMI who report having a place to live that is comfortable for them	Numerator: Number of adults with an SPMI who report having a place to live that is comfortable for them Denominator: total number of persons interviewed.	Member Data to be gathered by the CONTRACTOR phone interviews with Members	The phone survey universe is derived from a random sample of active mental health consumers in the established region.
Decrease in Institutional Care Utilization Outcomes	The CONTRACTOR will decrease utilization of institutional care. Each of the following categories of institutional care will be measured separately. The indicator will be measured by regions as established by the CONTRACTOR and	Numerator: Number of bed days utilized from CMHC catchment area Denominator: Number of persons per ten thousand living in the CMHC catchment area	CONTRACTOR MIS, and AIMS data, IPS, and state mental health hospital data.	Quarterly

	as approved by SRS.			
Inpatient Recidivism at 30 days, 90 days and one year post-discharge	The CONTRACTOR will monitor and report the percentage of re-admissions at 30 days, 90 days and one year from last discharge from each of the following categories: • State mental health hospitals, alternatives to state mental health hospitals, and Medicaid funded community hospital psychiatric inpatient programs for children and youth; • State mental health hospitals and Medicaid funded community hospital inpatient programs for adults; • Nursing Facilities for Mental Health; and • Psychiatric Residential Treatment Facilities. This measure will be considered as part of the CONTRACTOR's Outlier Management Program. The indicator will be measured by regions as established by the CONTRACTOR as approved by SRS. Any region and/or individual provider that falls within one standard deviation of the mean will result in a corrective action plan.	The number of inpatient discharges at 0-30 days and 31-90 days from last discharge of persons in the CMHC catchment area. Denominator: The number of inpatient discharges from the CMHC catchment area.	Hospital discharge reports, PRTF discharge reports, SRS-supplied discharge data	Quarterly
Average length of stay for Psychiatric Residential Treatment Facilities	Average Length of Stay for youth admitted to Psychiatric Residential Treatment Facility will be 100 days or lower. The indicator will be measured by regions as established by the CONTRACTOR as approved by SRS.	The CONTRACTOR will focus monitoring and performance improvement efforts on those CMHC catchment areas with higher ALOS than the statewide average. The CONTRACTOR will provide in its report an analysis of performance and a plan for performance improvement by CMHC catchment area	Numerator: Sum of days per child for children and youth discharged from Psychiatric Residential Treatment Facilities. Denominator: Total number of children and youth discharged from Psychiatric Residential Treatment Facilities.	claims data, IPS

Access to initial appointments	The CONTRACTOR will ensure providers offer timely initial appointments. 85% of Members will be offered an initial appointment within 10 calendar days	The CONTRACTOR will focus monitoring and performance improvement efforts on those providers with lower percentages than the established performance target. The CONTRACTOR will provide in its report an analysis of performance and a plan for performance improvement by provider.	Numerator: Members who are provided services within 10 calendar days of the request for an appointment Denominator: Total number of new Members who request an appointment within the reporting timeframe	Quarterly
Access standards for post-stabilization in an Emergency setting	The contactor will maintain the following access standards for screening for institutional care. Post-Stabilization 1 hour within 1 hour from initial contact to arrival of provider in an emergency room Emergent Immediate within 1 hour Urgent 24 hours 24 hours from referral	Performance is measured from the time of the initial call to the screener's arrival time location. The CONTRACTOR will focus monitoring and performance improvement efforts on those catchment areas with lower percentages than the statewide average. The CONTRACTOR will provide in its report an analysis of performance and a plan for performance improvement.	Claims data and CONTRACTOR MIS	Quarterly
Resolution of appeals	The CONTRACTOR will ensure that 95% of appeals are resolved as expeditiously as the Member's health condition requires and within 14 calendar days from the date the CONTRACTOR received the appeal, other than in instances which the Member has requested or SRS has approved an extension. 100% must be resolved within 45 calendar days from the date the CONTRACTOR received the appeal, even in the event of an extension.	Numerator: Number of Appeals resolved within 14 days Denominator: Total number of Appeals	CONTRACTOR MIS	Quarterly
Resolution of expedited	The CONTRACTOR will ensure that 95% of expedited appeals are resolved	Numerator: Number of Expedited Appeals resolved within 3 calendar	CONTRACTOR MIS	Quarterly

appeals	as expeditiously as the Member's health condition requires and within 3 working days from the date the CONTRACTOR received the appeal, other than in instances which the Member has requested or SRS has approved an extension. 100% must be resolved within 45 calendar days from the date the CONTRACTOR received the appeal, even in the event of an extension.	days Denominator: Total Number of Expedited Appeals received		
Penetration Rates for target populations (SPMI and SED)	The CONTRACTOR will maintain the penetration rates for Severe and Persistent Mental Illness (SPMI) at 29% and Serious Emotional Disturbance (SED) at 64% for individuals that have received either a Community Support Service (CSS) or Community Based Service (CBS) in the last six months. The indicator will be measured individually in each separate region. Regions will be established by the CONTRACTOR as approved by SRS.	Numerator: Number of Members with an SPMI (or SED) who have received Community Support Services (CSS) (or CBS)in the last six months Total population of catchment area per 10,000 total population Denominator: Total population of catchment area per 10,000 total population	CONTRACTOR MIS, AIMS system	Quarterly
SPMI adult Members competitively employed	The CONTRACTOR will maintain or increase percentage of Members identified as SPMI competitively employed. The indicator will be measured individually by each separate region. Regions will be established by the CONTRACTOR as approved by SRS.	Numerator: Number of SPMI adult Members receiving Community Support Services in the last six months that are competitively employed Denominator: Total Number of SPMI adult Members receiving Community Support Services in the last six months	AIMS system and claims data.	Quarterly
SED youth residing in a permanent family home setting	The CONTRACTOR will maintain or increase the percentage of SED Youth Members who are residing in a permanent family home setting at 88%. The indicator will be measured individually by each separate region. Regions will be established by the CONTRACTOR as approved	Numerator: Number of SED Youth receiving Community Based Services in the last six months that are residing in a permanent family home setting Denominator: Total Number of SED youth receiving Community Based Services in the last six months	AIMS system and claims data.	Quarterly

HCBS SED Waiver penetration rates	The CONTRACTOR will maintain the penetration rate of all HCBS SED Waiver services provided to SED Waiver participants for over-and under-utilization by mental health catchment area and by statewide average per 1,000 Members. This measure will be considered as part of the CONTRACTOR's Outlier Management Program. The indicator will be measured by regions as established by the CONTRACTOR as approved by SRS. Any region and/or individual provider that falls within one standard deviation of the mean will result in a corrective action plan.	Numerator: Number of SED Waiver Participants identified in the catchment area Denominator: Total population of catchment area per 1,000 Members	CONTRACTOR MIS Eligibility File, claims data	Quarterly
AIMS Reporting	The percentage of youth with an SED receiving CBS who attend school regularly will be maintained at 96%. The indicator will be measured individually by each separate region. Regions will be established by the CONTRACTOR as approved by SRS.	Numerator: Number of youth with an SED that have received CBS services within the last six months who are attending school with less than 5 unexcused absences. Denominator: Total number of youth with an SED that have received CBS services within the last six months.	AIMS system/Client Status Reports (CSR)	Twice Yearly
AIMS Reporting	The CONTRACTOR will maintain per capita number of admissions of persons from the CMHC's catchment to each of the following service categories: State mental health hospitals, alternatives to state mental health hospitals and Medicaid funded community hospital psychiatric inpatient programs for children and youth PRTFs and NFMH. This measure will be considered as part of the CONTRACTOR's Outlier Management Program. The indicator will be measured individually by each separate region. Regions will be established by the CONTRACTOR as approved by SRS.	Numerator: Number of admissions from CMHC catchment area Denominator: Number of persons per ten thousand living in the CMHC catchment area	Inpatient Screening Database, Medicaid Management Information System, Governor's Economic and Demographic Report.	Quarterly

SPMI adults living independently	The CONTRACTOR will maintain the rates of SPMI who live independently at 79%. The indicator will be measured individually by each separate region. Regions will be established by the CONTRACTOR as approved by SRS.	Numerator: Number of Members with an SPMI that have received CSS services in the last six months who are living independently. Denominator: Total number of Members with an SPMI that have received CSS services in the last six months	AIMS system/Client Status Reports (CSR)	Quarterly
HCBS SED Waiver	100% of clinical eligibility exception requests will receive a response from the Operating Agency within the three business days required timeframe.	N=The number of clinical eligibility exception requests that received a response within three business days. D=The total number of clinical eligibility exception requests.	Clinical Eligibility Database	Quarterly/Annual
HCBS SED Waiver	100% of participants reviewed will have a POC that were adequate and appropriate to their needs (including health care needs) as indicated in their assessments.	N=the number of charts reviewed with evidence the POC was adequate/appropriate to address the participant's needs (including health care needs). D=the total number of charts reviewed.	Chart Review Data	Quarterly/Annual
HCBS SED Waiver	100% percent of participants reviewed POC's have adequate and appropriate strategies to address their safety risks as in indicated in their assessments.	N=the number of charts reviewed with evidence the POC was adequate/appropriate to address the participant's safety risks. D=total number of charts reviewed	Chart Review Data	Quarterly/Annual
HCBS SED Waiver	100% of POCs address goals as indicated in the participants' assessments.	N=the number of charts reviewed with evidence the goals documented in the POC were addressed. D=total number of charts reviewed	Chart Review Data	Quarterly/Annual
HCBS SED Waiver	100% of participants' POC include the participant's and or parent or caregiver's signature as specified in the approved SED Waiver.	N=The number of charts reviewed with evidence the POC includes the participant and/or caregiver signature. D=the total number of charts reviewed	Chart Review Data	Quarterly/Annual

HCBS SED Waiver	100% of participants' POC are developed by a wraparound team.	N=the number of charts reviewed with evidence the POC was developed by a wraparound team. D=the total number of charts reviewed.	Chart Review Data	Quarterly/Annual
HCBS SED Waiver	100% of participants POC will be reviewed within 90 days of the last review.	N=the number of SED Waiver participants whose POC was reviewed for needed changes within 90 days of the last review. D=the total number of active SED Waiver participants	CONTRACTOR Report	Monthly
HCBS SED Waiver	100% of participants POCs will be updated when warranted by changes in participant needs.	N=The number of SED Waiver participants whose POC was updated. D=the total number of active SED Waiver participants whose needs warranted a POC change.	CONTRACTOR Report	Monthly
HCBS SED Waiver	100% of participants will receive services as specified in the POC.	N=The number of SED Waiver participants who received services as specified in the POC. D=the total number of active SED Waiver participants whose claims were selected as part of the compliance review.	CONTRACTOR Report	Quarterly/Annual
HCBS SED Waiver	100% of participant records will contain an appropriately completed and signed FCAD (freedom of choice form) that specifies choice was offered between institutional and SED Waiver services.	N=The number of charts containing an appropriately competed and signed FCAD, showing a choice between institutional and SED Waiver services. D=the total number of charts reviewed.	Chart Review Data	Quarterly/Annual

HCBS SED Waiver	100% of participant records will contain an appropriate completed and signed FCAD (freedom of choice form) that specifies choices were offered among SED Waiver services and providers.	N=The number of charts containing an appropriately competed and signed FCAD, showing choices among SED Waiver services and providers. D=the total number of charts reviewed for SED Waiver participants with a start date on or after 9/1/2010.	Chart Review Data	Quarterly/Annual
HCBS SED Waiver	100% of provider agencies, who deliver SED Waiver services, initially meeting licensure requirements prior to furnishing SED Waiver services.	N=The number new SED Waiver providers initially meeting licensure requirements prior to furnishing services. D=the total number of new SED Waiver providers.	State Operating Agency Report	Annual
HCBS SED Waiver	100% of provider agencies, who deliver SED Waiver services, will continuously meet licensure requirements while furnishing SED Waiver services.	N=the number of SED Waiver providers continuously meeting licensure requirements D=the total number of SED Waiver providers.	State Operating Agency Report	Annual
HCBS SED Waiver	100% of provider agencies, who deliver SED Waiver services, will have an active agreement with the State Medicaid Fiscal Agent.	N=the number of provider agencies with an active agreement with the FA. D=the total number of provider agencies delivering SED Waiver services.	State Operating Agency Report	Annual
HCBS SED Waiver	100% of non-licensed/non-certified providers of SED Waiver services will meet training requirements.	N=The number of non-licensed/non-certified SED Waiver providers that met training requirements. D=the total number of non-licensed/non-certified SED Waiver providers that met training requirements.	Training Contractor Report	Monthly
HCBS SED Waiver	100% newly developed or revised provider training will be approved by the Operating Agency.	N=the number of newly developed or revised training that were approved by the Operating Agency. D=the total number of provider training modules implemented that were newly developed or revised during the reporting period.	Training Contractor Report	Annual

HCBS SED Waiver	100% of active providers (by provider type) will meet training requirements.	N=the number of active SED Waiver providers meeting the training requirements. D=the total number of active SED Waiver providers.	CONTRACTOR(S) Contractor Reporting	Annual
HCBS SED Waiver	100% of reports related to the abuse, neglect, or exploitation of participants where an investigation was initiated within the established time frames.	N=The number of reports of abuse, neglect or exploitation of a SED Waiver participant, where an investigation was initiated within the established time frame. D=The total number of abuse, neglect or exploitation reports.	SRS-CFS reports	Quarterly
HCBS SED Waiver	100% of participants will receive information on how to report suspected abuse, neglect, or exploitation of children.	N=The number of charts reviewed with evidence the participant received information on reporting suspected abuse, neglect or exploitation of children. D=The total number of abuse, neglect or exploitation reports.	Chart Review Data	Quarterly/Annual
HCBS SED Waiver	100% of participants will receive information regarding their rights to a State Fair Hearing via the Notice of Action (NOA) form.	N=The number of charts reviewed with evidence the participant received a Notice of Action form containing information regarding their rights to a State Fair Hearing. D=The total number of charts reviewed.	Chart Review Data	Quarterly/Annual
HCBS SED Waiver	100% of grievances filed by participants will be resolved within 14 calendar days according to approved SED Waiver guidelines.	N=The number of SED Waiver participant grievances resolved within 14 days. D=The total number of grievances filed by SED Waiver participants.	CONTRACTOR Report	Quarterly/Annual

HCBS SED Waiver	100% of allegations of abuse neglect or exploitation screened in, investigated, and will have a determination made within the required timeframe as indicated by SRS Children and Family Services Policies and Procedures.	N=The number of reports of abuse, neglect or exploitation for SED Waiver participants that had an investigation completed within the required timeframe. D=The total number of abuse, neglect or exploitation reports for SED Waiver participants.	CONTRACTOR Report	Quarterly
HCBS SED Waiver	100% of aggregated performance measure reports, generated by the Operating Agency and reviewed by the State Medicaid Agency, will contain discovery, remediation and system improvement efforts for ongoing compliance of the assurances.	N=The number of reports that were reviewed by the State Medicaid Agency. D=The number of aggregated performance measure reports.	State Operating Agency Report	Annual
HCBS SED Waiver	100% of SED Waiver amendments, renewals and financial reports will be approved by the State Medicaid Agency prior to implementation by the Operating Agency.	N=The number of SED Waiver amendments, renewals, and financial reports approved by the State Medicaid Agency prior to implementation. D=The total number of SED Waiver amendments, renewals, and financial reports.	State Operating Agency Report	Annual
HCBS SED Waiver	100% of SED Waiver concepts and policies requiring new or additional MMIS programming will be approved by the State Medicaid Agency prior to implementation by the Operating Agency.	N=The number of SED Waiver concepts and policies requiring MMIS programming that were approved by the State Medicaid Agency prior to implementation. D=The number of SED Waiver concepts and policies requiring new or additional MMIS programming.	State Operating Agency Report	Annual

HCBS SED Waiver	The number and percent of paid claims for SED Waiver services reviewed that did not result in recoupment.	N=The number of SED Waiver claims reviewed where the determination did not result in a recoupment. D=The total number of SED Waiver claims audited.	CONTRACTOR(S) CONTRACTOR Report	Quarterly
HCBS SED Waiver	The number and percent of claims verified through the CONTRACTOR(S) CONTRACTOR's compliance audit to have paid in accordance with the participant's SED Waiver service plan.	N=The number of SED Waiver claims paid in accordance with the POC. D=The total number of SED Waiver claims audited.	CONTRACTOR(S) CONTRACTOR Report	Quarterly

Appendix 3. Performance Measures: Substance Use Disorders

Indicator LD=Liquidated Damages if not met	Reporting Frequency	Methodology	Benchmark Objective
Appointment Access (LD) Referral timelines Urgent – means a service need that is not emergent and can be met by providing an assessment within 24 hours of the request for service, and treatment within 24 hours of the assessment, without resultant deterioration in the individual's functioning or worsening of his/her condition. If the client is pregnant, they are to be placed in the urgent category. Routine - a service need that is not urgent and can be met by receiving an assessment within 14 (calendar) days, and treatment within 14 calendar days of the assessment, without resultant deterioration in the individual's functioning or worsening of his/her condition. IV Drug Users – If a client has used IV drugs within the last 6 months, and they don't fall into the Emergent or Urgent categories because of clinical need, they will need to be placed in this category. Clients who have used IV drugs within the	Quarterly and Annually	Measures time between call, assessment and treatment. Utilization report to manage access to care performance guarantees based upon client level of urgency. There will be two versions of this report, one provided quarterly to show a monthly snapshot within the quarter, and one trended by fiscal year. Data is reported by funding source and in aggregate. *The Emergent category has been removed from this report as this category indicates a service need that must be met immediately because the individual is unsafe or his/her condition is deteriorating, therefore, no authorization is required.	**Standards:** Note: These are the minimum standards. All calls for all Members are clinically triaged to ascertain if a more urgent level of care is appropriate. Emergent: Means a service need that must be met immediately because the individual is unsafe or his or her condition is deteriorating. If caller is determined to be at risk of self-harm or harm to others, or is a medical detox risk, the Member requires immediate assistance and intervention, and is referred to a hospital detox setting. The need is rated as Emergent. Urgent: Members are assessed within 24 hours; services delivered within 48 hours from the initial contact Routine: Members assessed within 14 days of request for services and treatment services are delivered within 14 days of assessment IV Drug Users: Members receive treatment within 14 days of first contact.

<table>
<tr><td>last 6 months need to be seen for treatment within 14 (calendar) days of initial contact.</td><td></td><td></td><td></td></tr>
<tr><td>Network Adequacy Assurance and Geomapping (Medicaid)
GEO mapping and Density Report combined</td><td>Annually</td><td>The Density Report will be combined with the Geo Access report & will provide information on network adequacy. There will be a separate report per SRS region.

The Medicaid Geo Access report is combined with the Density report to provide network access information. The report is broken out by modality, and region. Detail by county will be provided if out of access.</td><td>Urban:100% of Member within standards

Suburban : 100% Members within standards

Rural: 100% Members within standards

Standards:
15/25/45 miles – Level 1 & 2
30/50/90 miles – Level 3 & 4</td></tr>
<tr><td>Out of State Placement Summary</td><td>Quarterly/Annual</td><td>The Out-of-State Placement Summary reports the clients that seek out of state services and the providers who provide service to out of state Members. The details of the report include number of unique clients, funding source, region break-out, service level assessed, and frequency (units).</td><td>Monitor for trends</td></tr>
<tr><td>Utilization Data

Over and Under Utilization Report

<table><tr><th>Higher Levels of Care Utilization</th></tr><tr><td>Detox</td></tr><tr><td>Intermediate</td></tr><tr><td>Reintegration</td></tr><tr><td>Hospital-based services</td></tr></table></td><td>Quarterly</td><td>Admissions/1000;visits/1000
(Medicaid only) then for all funding sources
# of admissions, ALOS, etc.

Utilization report including Hospital and community based acute Detox, Reintegration, and Intermediate split by adult/adolescent and Detox services. The report details include average covered lives/Per 1000 calculations for Medicaid only, and admissions and days. The report will be based on the service date begin and service date end & will provide the count of actual units. The report will be claim based as a rolling quarter to show a full year by 4th quarter. This report will be provided as an aggregate, as well as by SRS region.</td><td>Monitor for trends</td></tr>
</table>

Over and Under Utilization Report **Lower Levels of Care Utilization** Intensive outpatient Outpatient Case Management Peer Support Telemedicine Crisis Intervention Assessment	Quarterly	Utilization report including Intensive Outpatient, Outpatient and Other services. The report details include average covered lives/Per 1000 calculations and admissions and days. The report will be claim based as a rolling quarter to show a full year by 4th quarter. The report will be based on the service date begin and service date end & will provide the count of actual units. This report will be provided as an aggregate, as well as by SRS region.	Monitor for trends
Over and Under Utilization Report Inpatient and RTC Recidivism Rates	Annually	Readmission report showing recidivism for Higher Levels of Care within 30, 60, and 365 days. The report details include age band and gender, admissions in previous year, and total admits and percent readmission by day buckets. Data will be reported on an aggregate level only.	Review report for trends Will need two full years of data to calculate readmission rates. First year report will only show admits. Also, this report does not contain quarterly trending so in order to get a complete dataset, a 90 day lag is recommended.
Over and Under Utilization Higher Levels of Care Diagnosis	Quarterly & Annual	Utilization report including Hospital Detox, Reintegration, Intermediate split by adult/adolescent, and Social Detox services reported together. The report details include the diagnosis description to include 'abuse' or 'dependency' along with the total # of units and percent of total unit. The report will include a graph showing a visual representation of the diagnosis distribution. This report will be provided as an aggregate, as well as by SRS region. Diagnoses will be broken out to the 5th digit of detail.	Review report for trends

Over and Under Utilization Lower Levels of Care Diagnosis	Quarterly & Annual	Utilization report including Intensive Outpatient, Outpatient and Other services reported together and broken out by adult and adolescent. The report details include the diagnosis description to include 'abuse' or 'dependency' along with the total # of units and percent of total unit. The report will include a graph showing a visual representation of the diagnosis distribution. This report will be provided as an aggregate, as well as by SRS region. Diagnoses will be broken out to the 5th digit of detail.	Review Report for Trends
Over and Under Utilization Report Average LOS, admissions and readmissions of all providers	Annually	Utilization report to determine over and underutilization. Report is broken out by all providers and reported separately by modality. The report will be delivered annually and will contain a rolling 12 months of data of all programs split by adult/adolescent including higher levels of care (hospital detox, social detox, reintegration, intermediate) and lower levels of care (intensive outpatient, outpatient and other). Graphs show Mean of length of stay (LOS) and one (1) Standard Deviation (SD) above and below the Mean for each provider over the entire rolling reporting period.	Analysis: Documentation and investigation of providers with LOS < or > 1SD from modality Mean.
Grievance Report Grievance Summary by Region, Grievance Client Detail, Grievance Provider Detail	Annually	By category, by region, by type, timeliness of resolution Grievance Summary by Region, Grievance Client Detail, Grievance Provider Detail	Monitor for Trends 95% resolved within 14 days receipt of all required documentation;100% resolved within 90 calendar days
Appeals Report Appeals Summary by Region, Appeals Detail, and Fair Hearing detail	Semi-annual and Annual	Standard and expedited appeals. Appeals Summary by Region, Appeals Detail; Appeals reporting will be provided by region and detail. Appeals are categorized as Clinical and Administrative.	Monitor for Trends **Standards:** <u>Denial letter notification:</u> -Level III – Denial letters must be sent within 3 days of the determination (100%);

			- Other Denials (Level 1 & 2) Denial letters must be sent within 14 days of the determination (100%) <u>Appeals:</u> -95% resolved within 14 days receipt of all required documentation; -100% resolved within 45 calendar days
Adverse Incident Report	Semi-annual and Annual	By category, by Region, by Provider as appropriate. Summary information that represents occurrences of actual or potential serious harm to the wellbeing of a SRS Member or to others by the actions of a SRS Member, who is receiving services managed by the CONTRACTOR or has recently been discharged from services managed by the CONTRACTOR.	100 % of sentinel and major Critical Incidents will be reported to the State immediately and investigated Chart review as appropriate. Monitor for trends; Goal: Decreasing incidents over time
Youth and Adults Discharged to Shelters	Quarterly	**For Youth**: The report shall include why the discharge was chosen and the names of those who gave consent to the discharge. The report will capture data for youth discharged to homeless shelters. **For Adults:** The report shall include why the discharge was chosen. The report will capture data for adults discharged to homeless shelters.	Monitor for trends
Network Inventory Comparison of # and types of providers before and after this contract	Annually	The Network Inventory report provides a snapshot of the network for a given year to compare annually. Report includes a summary page of modalities and provider counts.	No decrease in # of providers
Provider Network Expansion and Evaluation Plan	Semi-annually	The report shall include an analysis of the CONTRACTOR's network from the first day of the last fiscal year to the first day of the current fiscal year (example: 7/1/11 to 7/1/12). Evaluation is done twice a year for the current fiscal year and followed by an annual plan for the	Review and co-create this annual plan with the CONTRACTOR.

		next fiscal year.	
Provider Satisfaction Survey	Annually	Provider survey information presented in a scaling format regarding their experience with the CONTRACTOR.	Monitor for trends
Member Satisfaction Survey	Annually	Member survey information presented in a scaling format regarding their experience with the CONTRACTOR. Member random sample.	Monitor for trends
Penetration Rates Report	Monthly and Annually	Report of the Medicaid penetration rates, and new Members served each month.	.
Authorization Decisions Timeliness report	Monthly	Documents authorization decisions are occurring within the required timeframes. Data certification must be submitted concurrently	EQRO – BBA#4

Appendix 4. Performance Measures: MR/DD Waiver

Frequency of measuring	Methodology	Benchmark	Data source
Quarterly	D=Total number of new waiver provider applications, by provider type in sample vs. N=sample number of enrolled new waiver provider applications, by provider type, in which the provider obtained appropriate licensure/certification in accordance with State law and waiver provider qualifications prior to service provision.	100% of sample new providers have obtained appropriate licensure/certification (Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled providers, by provider type, meeting applicable licensure/certification requirements in sample vs. N= sample number of enrolled providers, by provider type, meeting applicable license / certification requirements following initial enrollment.	100% of sample enrolled providers meet applicable license / certification requirements (Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of new waiver provider applicants, by provider type in sample vs. N= sample number of new waiver provider applicants, by provider type, who meet initial waiver provider qualifications, including training requirements.	100% of sample new providers meet provider qualifications, including training requirements (Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of providers, by provider type in sample vs. N= sample number of providers, by provider type, continuing to meet waiver provider qualifications, including training requirements.	100% of sample enrolled providers meet provider qualifications, including training requirements(Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled waiver providers in sample vs. N= sample number of enrolled providers that have met established State training requirements in accordance with approved waiver.	100% of sample enrolled providers meet established training requirements(Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants vs. N=actual number of participants with service plans that address assessed functional needs during current service year.	100% of sample participants have service plans that address functional needs during service year. (Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants vs. N=actual number of participants with service plans that address health and safety risk factors during current service year.	100% of sample participants have service plans that address health and safety risk factors during service year. (Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument

Quarterly	D=Total number of enrolled participants vs. N=actual number of participants with service plans including personal goals during current service year.	100% of sample participants have service plans that address personal goals during the service year. (Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants with service plans developed in accordance with approved policies and procedures.	100% of sample participants have a service plan developed in accordance with approved procedures(Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants with service plans which are updated/revised annually during current service year.	100% of sample participants have service plan updated annually. (Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants with service plans which are updated/revised as warranted by participant's needs / preferred lifestyle during current service year.	100% of sample participants have service plans updated/revised as warranted by participants' needs. (Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants that verify they have received the appropriate services in the type, scope, amount and frequency as specified in their individual service plan	100% of sample participants receive services in the type, scope, and frequency identified in service plan(Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants whose records contain an appropriately completed and signed freedom of choice form that specifies choice was offered between HCBS Waiver Services and Institutional care.	100% of sample participants have signed freedom of choice form(Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants whose records contain documentation that specifies choice between and among HCBS Waiver Service providers..	100% of sample participants records have documentation that specifies choice of HCBS provider(Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled waiver participants / families in sample vs. N=sample number of participants/families that identify they know how to prevent, protect from, and report abuse, neglect and exploitation	100% of sample participants / families know how to identify, prevent and protect from abuse, neglect and exploitation. (Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument

Quarterly	D=Total number of enrolled waiver providers in sample vs. N=sample number of providers with verification that adequate training to prevent, protect from, and report abuse, neglect and exploitation.	100% of sample providers have adequate training to prevent, protect from and report abuse, neglect and exploitation. (Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Quality Review Instrument
Quarterly	D=Total number of each type of incident investigated vs. N= total number of each type of incident reported	100% of ANE reports are screened for appropriate investigation(Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Protective Services Data Base
Quarterly	D=Total number of each type of substantiated allegation vs. N= total number of each type investigated.	100% of ANE reports are appropriately substantiated. (Sample is 95% confidence level with +/- 5% margin of error; approx. 930 people)	Protective Services Data Base
Quarterly	Claims received and coded in accordance with the reimbursement methodology specified in the approved waiver vs. claims paid for in accordance with the reimbursement methodology specified in the approved waiver	100% of claims paid are in accordance with the reimbursement methodology specified in the waiver	CONTRACTOR(S)
Quarterly	Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver vs. number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver.	100% of claims not in accordance with the reimbursement methodology are denied/suspended.	CONTRACTOR(S)
Quarterly	Number of service recipient records with appropriate documentation to support paid claims vs. total number of service recipient records reviewed.	100% of claims paid are supported with appropriate documentation.	CONTRACTOR(S)

Appendix 5. Performance Measures: PD Waiver

Frequency of measuring	Methodology	Benchmark	Data source
Quarterly	D=Total number of new waiver provider applications, by provider type in sample vs. N=sample number of enrolled new waiver provider applications, by provider type, in which the provider obtained appropriate licensure/certification in accordance with State law and waiver provider qualifications prior to service provision.	100% of sample new providers have obtained appropriate licensure/certification(Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people	Quality Review Instrument
Quarterly	D=Total number of enrolled providers, by provider type, meeting applicable licensure/certification requirements in sample vs. N= sample number of enrolled providers, by provider type, meeting applicable license / certification requirements following initial enrollment	100% of sample enrolled providers meet applicable license / certification requirements (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument
Quarterly	D=Total number of new waiver provider applicants, by provider type in sample vs. N= sample number of new waiver provider applicants, by provider type, who meet initial waiver provider qualifications, including training requirements.	100% of sample new providers meet provider qualifications, including training requirements(Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument
Quarterly	D=Total number of providers, by provider type in sample vs. N= sample number of providers, by provider type, continuing to meet waiver provider qualifications, including training requirements.	100% of sample enrolled providers meet provider qualifications, including training requirements (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled waiver providers in sample vs. N= sample number of enrolled providers that have met established State training requirements in accordance with approved waiver.	100% of sample enrolled providers meet established training requirements (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants vs. N= actual number of participants with service plans that address assessed functional needs during current service year.	100% of sample participants have service plans that address functional needs during service year. (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants vs. N=actual number of participants with service plans that address health and safety risk factors during current service year.	100% of sample participants have service plans that address health and safety risk factors during service year. (Sample is 95%	Quality Review Instrument

		confidence level with +/- 5% margin of error; approx. 800 people)	
Quarterly	100% of sample participants have service plans that address personal goals during the service year. (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	D=Total number of enrolled participants vs. N= actual number of participants with service plans including personal goals during current service year.	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants with service plans developed in accordance with approved policies and procedures.	100% of sample participants have a service plan developed in accordance with approved procedures(Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants with service plans which are updated/revised annually during current service year.	100% of sample participants have service plan updated annually. (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants with service plans which are updated/revised as warranted by participant's needs / preferred lifestyle during current service year.	100% of sample participants have service plans updated/revised as warranted by participants' needs. (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants that verify they have received the appropriate services in the type, scope, amount and frequency as specified in their individual service plan	100% of sample participants receive services in the type, scope, and frequency identified in service plan (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants whose records contain an appropriately completed and signed freedom of choice form that specifies choice was offered between HCBS Waiver Services and Institutional care.	100% of sample participants have signed freedom of choice form (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants whose records contain documentation that specifies choice between and among HCBS Waiver Service providers.	100% of sample participants records have documentation that specifies choice of HCBS provider (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled waiver participants / families in sample vs. N= sample number of participants/families that identify they know how to prevent, protect from, and report abuse, neglect and exploitation.	100% of sample participants / families know how to identify, prevent and protect from abuse, neglect and exploitation. (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument

Quarterly	D=Total number of enrolled waiver providers in sample vs. N= sample number of providers with verification that adequate training to prevent, protect from, and report abuse, neglect and exploitation.	100% of sample providers have adequate training to prevent, protect from and report abuse, neglect and exploitation. (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument
Quarterly	D=Total number of each type of incident investigated vs.N= total number of each type of incident reported	100% of ANE reports are screened for appropriate investigation (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Protective Services Data Base
Quarterly	D=Total number of each type of substantiated allegation vs. N=total number of each type investigated.	100% of ANE reports are appropriately substantiated.	Protective Services Data Base
Quarterly	D=Claims received and coded in accordance with the reimbursement methodology specified in the approved waiver vs. N=claims paid for in accordance with the reimbursement methodology specified in the approved waiver	100% of reviewed claims paid are in accordance with the reimbursement methodology specified in the waiver	CONTRACTOR(S)
Quarterly	D=Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver vs. N= number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver.	100% of reviewed claims not in accordance with the reimbursement methodology are denied/suspended.	CONTRACTOR(S)
Quarterly	N=Number of service recipient records with appropriate documentation to support paid claims vs. D= total number of service recipient records reviewed.	100% of reviewed claims paid are supported with appropriate documentation.	CONTRACTOR(S)
Quarterly	N=Number of EVV claims paid per billing agency vs. D= total number of FMS providers enrolled.	100% of FMS Providers utilize Electronic Visit Verification	CONTRACTOR(S)
Quarterly	D=Total number of enrolled waiver participants vs.N= sample number of participants who report needs met.	100% of sample participants report health, safety and welfare needs met. (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument
Annually	D=Total number of enrolled waiver participants vs. N=sample number of participants who receive an annual reassessment of functional needs.	100% of sample participants have functional redeterminations completed annually. (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument, Uniform Assessment Instruments

Quarterly	D=Total number of enrolled self-directing waiver participants vs. N= sample number of participants who self-direct their services	100% of sample self-directing sample participants have received adequate I & A from their FMS provider. (Sample is 95% confidence level with +/- 5% margin of error; approx. 800 people)	Quality Review Instrument

Appendix 6. Performance Measures: TBI Waiver

Frequency of measuring	Methodology	Benchmark	Data source
Quarterly	D=Total number of new waiver provider applications, by provider type in sample vs. N=sample number of enrolled new waiver provider applications, by provider type, in which the provider obtained appropriate licensure/certification in accordance with State law and waiver provider qualifications prior to service provision.	100% of sample new providers have obtained appropriate licensure/certification (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled providers, by provider type, meeting applicable licensure/certification requirements in sample vs. N=sample number of enrolled providers, by provider type, meeting applicable license / certification requirements following initial enrollment.	100% of sample enrolled providers meet applicable license / certification requirements (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of new waiver provider applicants, by provider type in sample vs. N=sample number of new waiver provider applicants, by provider type, who meet initial waiver provider qualifications, including training requirements.	100% of sample new providers meet provider qualifications, including training requirements(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of providers, by provider type in sample vs. N=sample number of providers, by provider type, continuing to meet waiver provider qualifications, including training requirements.	100% of sample enrolled providers meet provider qualifications, including training requirements(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled waiver providers in sample vs. N=sample number of enrolled providers that have met established State training requirements in accordance with approved waiver.	100% of sample enrolled providers meet established training requirements(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants vs. N=actual number of participants with service plans that address assessed functional needs during current service year.	100% of sample participants have service plans that address functional needs during service year. (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants vs. N= actual number of participants with service plans that address health and safety risk factors during current service year.	100% of sample participants have service plans that address health and safety risk factors during service year. (Sample is 95% confidence level with +/- 5% margin of error;	Quality Review Instrument

		approx. 200 people)	
Quarterly	D=Total number of enrolled participants vs. N= actual number of participants with service plans including personal goals during current service year.	100% of sample participants have service plans that address personal goals during the service year. (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants with service plans developed in accordance with approved policies and procedures.	100% of sample participants have a service plan developed in accordance with approved procedures(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants with service plans which are updated/revised annually during current service year.	100% of sample participants have service plan updated annually. (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants with service plans which are updated/revised as warranted by participant's needs / preferred lifestyle during current service year.	100% of sample participants have service plans updated/revised as warranted by participants' needs. (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants that verify they have received the appropriate services in the type, scope, amount and frequency as specified in their individual service plan	100% of sample participants receive services in the type, scope, and frequency identified in service plan(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants whose records contain an appropriately completed and signed freedom of choice form that specifies choice was offered between HCBS Waiver Services and Institutional care.	100% of sample participants have signed freedom of choice form(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants whose records contain documentation that specifies choice between and among HCBS Waiver Service providers.	100% of sample participants records have documentation that specifies choice of HCBS provider(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument

Quarterly	D=Total number of enrolled waiver participants / families in sample vs. N=sample number of participants/families that identify they know how to prevent, protect from, and report abuse, neglect and exploitation	100% of sample participants / families know how to identify, prevent and protect from abuse, neglect and exploitation. (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled waiver providers in sample vs. N= sample number of providers with verification that adequate training to prevent, protect from, and report abuse, neglect and exploitation.	100% of sample providers have adequate training to prevent, protect from and report abuse, neglect and exploitation. (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Protective Services Data Base
Quarterly	D=Total number of each type of incident investigated vs. N= total number of each type of incident reported	100% of ANE reports are screened for appropriate investigation(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Protective Services Data Base
Quarterly	N=Total number of each type of substantiated allegation vs. D= total number of each type investigated.	100% of ANE reports are appropriately substantiated.	CONTRACTOR(S)
Quarterly	N=Claims received and coded in accordance with the reimbursement methodology specified in the approved waiver vs. D=claims paid for in accordance with the reimbursement methodology specified in the approved waiver	100% of reviewed claims paid are in accordance with the reimbursement methodology specified in the waiver	CONTRACTOR(S)
Quarterly	N=Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver vs. D= number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver.	100% of reviewed claims not in accordance with the reimbursement methodology are denied/suspended.	CONTRACTOR(S)
Quarterly	N=Number of service recipient records with appropriate documentation to support paid claims vs. D=total number of service recipient records reviewed.	100% of reviewed claims paid are supported with appropriate documentation.	CONTRACTOR(S)
Annually	N=Number of persons making progress vs. D= total # of persons receiving services	90% of persons receiving waiver services are making progress in rehabilitation and/or independent living skills training	TBI UAI and Addendum scores; TLS progress notes; therapy progress notes

Appendix 7. Performance Measures: TA Waiver

Frequency of measuring	Methodology	Benchmark	Data source
Bi-annually	N= sample number of hospitalizations within the 6 months for the same children admitted to program D=Total number of children assessed for program eligibility	10% Percentage of children with re-hospitalization within the first 6 months of program admission	CONTRACTOR/ chart review
Bi-annually	N= number of children with unplanned hospitalization greater than 7 days D=Total number of children in the program	10% Percentage of children hospitalized greater than 7 days for unplanned acute illnesses	CONTRACTOR/ chart review
Bi-annually	N= number of deaths due to natural disease processes D=Total number of deaths reported while active in the program	100% percentage of deaths reported due to normal disease process	Contracted provider source
Bi-annually	N= number of children living with single parent D= number of children in biological home	Percentage of Single parent home	Contracted provider source
Bi-annually	N= number of children living with two parents D= number of children in biological home	Percentage of two parent homes	CONTRACTOR
Bi-annually	N=number of children living in foster care homes by age D=Total number of children in program	Percentage of children in foster care homes by age	Contracted provider source
Bi-annually	N=number of children attending school D=Total number children age-eligible to attend school	Percentage of individuals who are age-eligible who attends school	Contracted provider source
Bi-annually	N=number of individuals desiring to work D=Total number of individuals age-eligible to work	Percentage of individuals who are age-eligible who wish to work	Contracted provider source
Bi-annually	N=number of children electing TA and hospice services D= Total number of children on the program	5% of individuals receiving concurrent care: TA and hospice services	Contracted provider source
Quarterly	D=total number of new waiver provider applications, by provider type in sample vs. sample number of enrolled new waiver provider applications, by provider type, in which the provider obtained appropriate licensure/certification in accordance with State law and waiver provider qualifications prior to service provision.	100% of sample new providers have obtained appropriate licensure/certification(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument

Quarterly	D=Total number of enrolled providers, by provider type, meeting applicable licensure/certification requirements in sample vs. N= sample number of enrolled providers, by provider type, meeting applicable license / certification requirements following initial enrollment.	100% of sample enrolled providers meet applicable license / certification requirements (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of new waiver provider applicants, by provider type in sample vs. N= sample number of new waiver provider applicants, by provider type, who meet initial waiver provider qualifications, including training requirements.	100% of sample new providers meet provider qualifications, including training requirements(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of providers, by provider type in sample vs. N= sample number of providers, by provider type, continuing to meet waiver provider qualifications, including training requirements.	100% of sample enrolled providers meet provider qualifications, including training requirements(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled waiver providers in sample vs. N= sample number of enrolled providers that have met established State training requirements in accordance with approved waiver.	100% of sample enrolled providers meet established training requirements(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants vs. N= actual number of participants with service plans that address assessed functional needs during current service year.	100% of sample participants have service plans that address functional needs during service year. (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants vs. N= actual number of participants with service plans that address health and safety risk factors during current service year.	100% of sample participants have service plans that address health and safety risk factors during service year. (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants vs. N= actual number of participants with service plans including personal goals during current service year.	100% of sample participants have service plans that address personal goals during the service year. (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants with service plans developed in accordance with approved policies and procedures.	100% of sample participants have a service plan developed in accordance with approved procedures (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument

Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants with service plans which are updated/revised annually during current service year.	100% of sample participants have service plan updated annually. (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants with service plans which are updated/revised as warranted by participant's needs / preferred lifestyle during current service year.	100% of sample participants have service plans updated/revised as warranted by participants' needs. (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants that verify they have received the appropriate services in the type, scope, amount and frequency as specified in their individual service plan	100% of sample participants receive services in the type, scope, and frequency identified in service plan(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants whose records contain an appropriately completed and signed freedom of choice form that specifies choice was offered between HCBS Waiver Services and Institutional care.	100% of sample participants have signed freedom of choice form(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants whose records contain documentation that specifies choice between and among HCBS Waiver Service providers.	100% of sample participants records have documentation that specifies choice of HCBS provider(Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled waiver participants / families in sample vs. N= sample number of participants/families that identify they know how to prevent, protect from, and report abuse, neglect and exploitation	100% of sample participants / families know how to identify, prevent and protect from abuse, neglect and exploitation. (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of enrolled waiver providers in sample vs. N= sample number of providers with verification that adequate training to prevent, protect from, and report abuse, neglect and exploitation.	100% of sample providers have adequate training to prevent, protect from and report abuse, neglect and exploitation. (Sample is 95% confidence level with +/- 5% margin of error; approx. 200 people)	Quality Review Instrument
Quarterly	D=Total number of each type of incident investigated vs. N= total number of each type of incident reported	100% of ANE reports are screened for appropriate investigation	Protective Services Data Base
Quarterly	D=Total number of each type of substantiated allegation vs. N= total number of each type investigated.	100% of ANE reports are appropriately substantiated.	Protective Services Data Base

Quarterly	Claims received and coded in accordance with the reimbursement methodology specified in the approved waiver vs. claims paid for in accordance with the reimbursement methodology specified in the approved waiver	100% of claims paid are in accordance with the reimbursement methodology specified in the waiver	CONTRACTOR(S)
Quarterly	Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver vs. number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver.	100% of claims not in accordance with the reimbursement methodology are denied/suspended.	CONTRACTOR(S)
Quarterly	Number of service recipient records with appropriate documentation to support paid claims vs. total number of service recipient records reviewed.	100% of claims paid are supported with appropriate documentation.	CONTRACTOR(S)

Appendix 8. Performance Measures: Autism Waiver and ICF/MRs

Program involved	Frequency of measuring	Methodology	Benchmark	Data source
Autism Waiver	Quarterly	D=Total number of new waiver provider applications, by provider type in sample vs. N= sample number of enrolled new waiver provider applications, by provider type, in which the provider obtained appropriate licensure/certification in accordance with State law and waiver provider qualifications prior to service provision.	100% of sample new providers have obtained appropriate licensure/certification(Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	D=Total number of enrolled providers, by provider type, meeting applicable licensure/certification requirements in sample vs. N=sample number of enrolled providers, by provider type, meeting applicable license / certification requirements following initial enrollment.	100% of sample enrolled providers meet applicable license / certification requirements (Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	D=Total number of new waiver provider applicants, by provider type in sample vs. N= sample number of new waiver provider applicants, by provider type, who meet initial waiver provider qualifications, including training requirements.	100% of sample new providers meet provider qualifications, including training requirements(Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	D=Total number of providers, by provider type in sample vs. N= sample number of providers, by provider type, continuing to meet waiver provider qualifications, including training requirements.	100% of sample enrolled providers meet provider qualifications, including training requirements(Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	D=Total number of enrolled waiver providers in sample vs. N= sample number of enrolled providers that have met established State training requirements in accordance with approved waiver.	100% of sample enrolled providers meet established training requirements(Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	D=Total number of enrolled participants vs. N= actual number of participants with service plans that address assessed functional needs during current service year.	100% of sample participants have service plans that address functional needs during service year. (Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument

Autism Waiver	Quarterly	D=Total number of enrolled participants vs. N=actual number of participants with service plans that address health and safety risk factors during current service year.	100% of sample participants have service plans that address health and safety risk factors during service year. (Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	D=Total number of enrolled participants vs. N= actual number of participants with service plans including personal goals during current service year.	100% of sample participants have service plans that address personal goals during the service year. (Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants with service plans developed in accordance with approved policies and procedures.	100% of sample participants have a service plan developed in accordance with approved procedures(Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants with service plans which are updated/revised annually during current service year.	100% of sample participants have service plan updated annually. (Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants with service plans which are updated/revised as warranted by participant's needs / preferred lifestyle during current service year.	100% of sample participants have service plans updated/revised as warranted by participants' needs. (Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants that verify they have received the appropriate services in the type, scope, amount and frequency as specified in their individual service plan	100% of sample participants receive services in the type, scope, and frequency identified in service plan(Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants whose records contain an appropriately completed and signed freedom of choice form that specifies choice was offered between HCBS Waiver Services and Institutional care.	100% of sample participants have signed freedom of choice form(Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument

Autism Waiver	Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants whose records contain documentation that specifies choice between and among HCBS Waiver Service providers.	100% of sample participants records have documentation that specifies choice of HCBS provider(Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	D=Total number of enrolled waiver participants / families in sample vs. N= sample number of participants/families that identify they know how to prevent, protect from, and report abuse, neglect and exploitation	100% of sample participants / families know how to identify, prevent and protect from abuse, neglect and exploitation. (Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	D=Total number of enrolled waiver providers in sample vs. N= sample number of providers with verification that adequate training to prevent, protect from, and report abuse, neglect and exploitation.	100% of sample providers have adequate training to prevent, protect from and report abuse, neglect and exploitation. (Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Quality Review Instrument
Autism Waiver	Quarterly	N=Total number of each type of incident investigated vs. D=total number of each type of incident reported	100% of ANE reports are screened for appropriate investigation(Sample is 95% confidence level with +/- 5% margin of error; approx. 50 people)	Protective Services Data Base
Autism Waiver	Quarterly	N=Total number of each type of substantiated allegation vs. D=total number of each type investigated.	100% of ANE reports are appropriately substantiated.	Protective Services Data Base
Autism Waiver	Quarterly	Claims received and coded in accordance with the reimbursement methodology specified in the approved waiver vs. claims paid for in accordance with the reimbursement methodology specified in the approved waiver	100% of claims paid are in accordance with the reimbursement methodology specified in the waiver	CONTRACTOR(S)
Autism Waiver	Quarterly	Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver vs. number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver.	100% of claims not in accordance with the reimbursement methodology are denied/suspended.	CONTRACTOR(S)
Autism Waiver	Quarterly	N=Number of service recipient records with appropriate documentation to support paid claims vs. D=total number of service recipient records reviewed.	100% of reviewed claims paid are supported with appropriate documentation.	CONTRACTOR(S)

Autism Waiver	Annually	N=Number of Participants Vineland II adaptive behavioral scores and composite scores from reassessments show an increase vs. D=Number of participants Vineland II adaptive behavioral scores and composite scores from reassessments are unchanged or decline.	The Vineland scores show a 40% overall improvement for participants on the waiver	CONTRACTOR - KVC
Private ICF/MR	Prior to admission	N= Number of participants in an ICF/MR setting has had gatekeeping completed prior to admission vs. D= total number of participants in an ICF/MR setting	100% of all admissions to the ICF/MR have gone through the LOC assessment process completed by the Local CDDO	ICF Program Manager
Private ICF/MR	Prior to admission	N= number of "participants who have a guardian" who have obtained court approval prior to admission vs. D= total number of “participants” in an ICF/MR setting	100% of those participants who are "ward of the court" seeking admission to an ICF/MR have obtained courts' approval	ICF Program Manager
Private ICF/MR	Annually	N= number of participants in an ICF/MR meet active treatment guidelines vs. D= total number of participants in ICF/MR.	100 % of all admissions to an ICF/MR meet the Condition of participation: Active treatment services	Cost report CONTRACTOR
Private ICF/MR	At a minimum annually	N= number of all participants will have a continuous active treatment program in place with 30 days of admission vs D= total number of participants in ICF/MR.	100% of all participants must receive a continuous active treatment program	KDOA Survey, Licensing and Certification Team
Private ICF/MR	Annually	N= Number of facilities operating will have cost reports completed and submitted timely vs. D= total number of operating facilities will have cost reports completed and submitted timely.	100% of all ICF/MR facilities will submit accurate and timely cost reports	Cost report CONTRACTOR
Private ICF/MR	Annually	N= Number of participants in an ICF/MR younger than 16 vs. D= total number of participants in an ICF/MR	100% of participants in an ICF/MR will not be younger than 16 years of age	KDOA Survey, Licensing and Certification Team
Private ICF/MR	Annually	N= Facility will be licensed and certified as either a small (4-8 bed) or medium (9-16 bed) size facility vs=D total number of facilities licensed and certified as either a small (4-8 bed) or medium (9-16 bed) size facility	100% of ICF/MR facilities will be either classified as small or medium size facility	KDOA Survey, Licensing and Certification Team

Appendix 9. Performance Measures: Money Follows the Person Grant (MR/DD, PD, TBI and FE)

Frequency of measuring	Methodology	Benchmark	Data source
Quarterly	D=Total number of new waiver provider applications, by provider type in sample vs. N= sample number of enrolled new waiver provider applications, by provider type, in which the provider obtained appropriate licensure/certification in accordance with State law and waiver provider qualifications prior to service provision.	100% of new providers have obtained appropriate licensure/certification (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of enrolled providers, by provider type, meeting applicable licensure/certification requirements in sample vs. N= sample number of enrolled providers, by provider type, meeting applicable license / certification requirements following initial enrollment.	100% of enrolled providers meet applicable license / certification requirements (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of new waiver provider applicants, by provider type in sample vs. N= sample number of new waiver provider applicants, by provider type, who meet initial waiver provider qualifications, including training requirements.	100% of new providers meet provider qualifications, including training requirements (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of providers, by provider type in sample vs. N= sample number of providers, by provider type, continuing to meet waiver provider qualifications, including training requirements.	100% of enrolled providers meet provider qualifications, including training requirements (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of enrolled waiver providers in sample vs. N=sample number of enrolled providers that have met established State training requirements in accordance with approved waiver.	100% of enrolled providers meet established training requirements (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants vs. N= actual number of participants with service plans that address assessed functional needs during current service year.	100% of participants have service plans that address functional needs during service year. (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants vs. N=actual number of participants with service plans that address health and safety risk factors during current service year.	100% of participants have service plans that address health and safety risk factors during service year. (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants vs. N=actual number of participants with service plans including personal goals during current service year.	100% of participants have service plans that address personal goals during the service year. (Approx. 250 are reviewed annually)	Quality Review Instrument

Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants with service plans developed in accordance with approved policies and procedures.	100% of participants have a service plan developed in accordance with approved procedures (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants with service plans which are updated/revised annually during current service year.	100% of participants have service plan updated annually. (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N=sample number of participants with service plans which are updated/revised as warranted by participant's needs / preferred lifestyle during current service year.	100% of participants have service plans updated/revised as warranted by participants' needs. (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants that verify they have received the appropriate services in the type, scope, amount and frequency as specified in their individual service plan	100% of participants receive services in the type, scope, and frequency identified in service plan (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants whose records contain an appropriately completed and signed freedom of choice form that specifies choice was offered between HCBS Waiver Services and Institutional care.	100% of participants have signed freedom of choice form (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of enrolled participants in sample vs. N= sample number of participants whose records contain documentation that specifies choice between and among HCBS Waiver Service providers.	100% of participants records have documentation that specifies choice of HCBS provider (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of enrolled waiver participants / families in sample vs. N=sample number of participants/families that identify they know how to prevent, protect from, and report abuse, neglect and exploitation	100% of participants / families know how to identify, prevent and protect from abuse, neglect and exploitation. (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of enrolled waiver providers in sample vs. N= sample number of providers with verification that adequate training to prevent, protect from, and report abuse, neglect and exploitation.	100% of providers have adequate training to prevent, protect from and report abuse, neglect and exploitation. (Approx. 250 are reviewed annually)	Quality Review Instrument
Quarterly	D=Total number of each type of incident investigated vs. N=total number of each type of incident reported	100% of ANE reports are screened for appropriate investigation	Protective Services Data Base
Quarterly	D=Total number of each type of substantiated allegation vs. N= total number of each type investigated.	100% of ANE reports are appropriately substantiated.	Protective Services Data Base

Quarterly	D=Claims received and coded in accordance with the reimbursement methodology specified in the approved waiver vs. N= claims paid for in accordance with the reimbursement methodology specified in the approved waiver	100% of referred claims paid are in accordance with the reimbursement methodology specified in the waiver	CONTRACTOR(S)
Quarterly	D=Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver vs. N= number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver.	100% of referred claims not in accordance with the reimbursement methodology are denied/suspended.	CONTRACTOR(S)
Quarterly	D=Number of service recipient records with appropriate documentation to support paid claims vs. N= total number of service recipient records reviewed.	100% of referred claims paid are supported with appropriate documentation.	CONTRACTOR(S)
1X during their MFP year.	D=Number of MFP transitionees who received a QA review N=compared with total number of transitionees.	100% of MFP participants who transition to the community receive a quality review during their MFP year.	Quality Review Instrument
QA visit during their MFP year.	D=Total # of people surveyed by MFP staff and entered by CONTRACTOR vs. N=number of surveys included in report	100% of MFP Quality review surveys completed by MFP staff are compiled & included in report by CONTRACTOR	MFP Quality Review Instrument
semi-annually	Total # of licensed ICF/MR beds during 6 month reporting period vs. total # of licensed ICF/MR beds during previous MFP reporting periods.	Report on number of private ICF/MR beds to track number closed via voluntary closure.	ICF/MR census data.
semi-annually	Total dollars spent on HCBS budget vs. N=total number of dollars spent on institutional costs.	Report on overall LTC spending to assure an annual percentage shift in spending as a result of an increase in spending on HCBS services and a decrease on institutional spending.	Budget documents
semi-annually	80% of annual transition benchmarks are achieved.	Compile report on progress towards reaching annual transition benchmarks. (Benchmarks are re-established by for each disability population annually e.g. 35 people with TBI complete MFP transition.)	MFP data
semi-annually	D= Total number of MFP participants annually vs. N= total number of MFP participants are re-institutionalized	Post transition success - 80% of people who transition will receive adequate services/supports to remain successfully in the community	KMAP POC data.
semi-annually	D= Total number of MFP participants annually vs. D=total number of MFP participants maintaining the same level of service after moving to HCBS	Continuity of Care - 100% of people who complete their MFP year will maintain the level of service/supports when moving over to the HCBS waiver.	KMAP POC data.

Appendix 10- Performance Measures: Frail Elderly Waiver

Indicator	Reporting Frequency	Methodology	Benchmark Objective
Access	Quarterly	Number of providers available in service areas	To be set by the State
Eligibility	Quarterly	Number and percent of participants meeting financial eligibility determination	100% of participants will meet financial eligibility determination
Plan of Care Development	Monthly	Percent of waiver participants whose Service Plans started within the number of specified days	100% of waiver participants' Service Plans started within the number of specified days
Plan of Care Development	Quarterly	Percent of service plans reviewed prior to annual redetermination	100% of service plans are reviewed prior to annual redetermination
Plan of Care Development	Monthly	Number of MMIS claims compared to documentation and service plan	As specified by the State
Choice	Quarterly	Percent of participants whose record contains a Customer Choice form indicating choice of community based services	100% of participants' records contain a Customer Choice form indicating choice of community based services
Choice	Quarterly	Percent of participants whose record contains a Customer Choice form indicating their choice to self-direct services	100% of participants' records contain a Customer Choice form indicating their choice to self-direct services
Choice	Quarterly	Percent of FE waiver participants whose record contains Customer Choice form indicating choice of service providers	100% of FE waiver participants' records contain Customer Choice form indicating choice of service providers
Health and Welfare	Quarterly	Number and percent of participants who have a backup plan for disaster	100% of participants will have a backup plan for disaster
Health and Welfare	Continuous	Number of APS or KDOA complaint line intakes for HCBS/FE participants	As specified by the State
Health and Welfare	Quarterly	Number of critical incidents reported by Case Management entities to SRS or KDOA's complaint hot line that are substantiated	As specified by the State
Health and Welfare	Annually	Percent of TCMs who have received training to educate participants on how to identify, protect from, and report abuse neglect and exploitation	100% of TCMs will have received training to educate participants on how to identify, protect from, and report abuse neglect and exploitation
Health and Welfare	Quarterly	Percent of waiver participants who report knowing how to prevent, protect from , and report abuse neglect and exploitation	100% of waiver participants will report knowing how to prevent, protect from , and report abuse neglect and exploitation
Financial Accountability	Quarterly	Percent of FE provider claims paid in accordance with the State's approved reimbursement methodology	100% of FE provider claims paid in accordance with the State's approved reimbursement methodology
Financial	Quarterly	Number of FE claims received that are not denied or	90% of clean nursing facility claims (claims that do

Accountability		suspended vs. number of FE claims not denied or suspended but paid within 14 days	not trigger an edit for denial or suspension) are processed within 14 days
Financial Accountability	Quarterly	Number of FE claims received that are not denied or suspended vs. number of FE claims not denied or suspended but paid within 21 days	99.5% of clean nursing facility claims (claims that do not trigger an edit for denial or suspension) are processed within 21 days
Financial Accountability	Quarterly	Number of FE claims received that are for Medicaid approved resident days vs. number of FE claims for Medicaid approved resident days that are paid within 21 days	100% of valid claims (Medicaid approved resident days) are processed within 60 days
Customer Satisfaction	Annually	Customer Satisfaction Survey	5% improvement in Member satisfaction rate

Appendix 11- Performance Measures: Nursing Facility

Indicator LD= Liquidated Damage if not met	Frequency of measuring	Methodology	Benchmark	Data source
Administrative Accountability	Quarterly	Total number of enrolled providers in sample vs. sample number of enrolled providers that obtained/maintained appropriate licensure/certification in accordance with State law and other provider qualifications prior to service provision.	100% of sample providers have obtained appropriate licensure/certification	Quality Review Instrument
Choice	Annually	Total number of sample residents vs. the total number of sample residents reporting being placed in a home of their choice.	95% of nursing facility residents report being placed in a nursing facility of their choice.	CONTRACTOR Customer Satisfaction Survey
Financial Accountability	Quarterly	Claims received and coded in accordance with the reimbursement methodology specified in the approved State plan vs. claims paid for in accordance with the reimbursement methodology specified in the approved State plan.	100% of claims paid are in accordance with the reimbursement methodology specified in the State plan.	CONTRACTOR's billing system
Financial Accountability	Quarterly	Number of nursing facility claims received that are not denied or suspended vs. number of nursing facility claims not denied or suspended but paid within 14 days.	90% of clean nursing facility claims (claims that do not trigger an edit for denial or suspension) are processed within 14 days.	CONTRACTOR's billing system
Financial Accountability (LD)	Quarterly	Number of nursing facility claims received that are not denied or suspended vs. number of nursing facility claims not denied or suspended but paid within 21 days.	99.5% of clean nursing facility claims (claims that don not trigger an edit for denial or suspension) are processed with 21 days.	CONTRACTOR's billing system
Financial Accountability	Quarterly	Number of nursing facility claims received that are for Medicaid approved resident days vs. number of nursing facility claims for Medicaid approved resident days that are paid within 21 days.	100% of valid claims (Medicaid approved resident days) are processed within 60 days.	CONTRACTOR's billing system
Financial Accountability	Quarterly	Number of service recipient records with appropriate documentation to support paid claims vs. total number of service recipient records reviewed.	100% of claims paid are supported with appropriate documentation.	CONTRACTOR's billing system

Health and Welfare	Annually	Total sample number of nursing facility residents receiving services between October and April vs. number of sample residents with documented flu vaccinations or declination of vaccination.	100% of nursing facility residents are given access to annual flu shots.	Annual Resurveys
Health and Welfare	Quarterly	Number of nursing facility admissions divided between; long-term admissions (greater than 90 days), short-term admissions (less than 90 days to discharge), and number of readmissions within 30 days of discharge.	Nursing facility admissions stratified by length of stay.	CONTRACTOR self reports
Health and Welfare (LD)	Quarterly	Total number of nursing facility discharges vs. total number of nursing facility discharges that also are readmitted to a hospital within 30 days.	Percent of hospital re-admissions within 30 days of nursing facility discharge.	CONTRACTOR self report
Choice	Quarterly	Total number of beneficiaries that transition from a nursing facility placement to a community placement.	Number of beneficiaries that transition from a nursing facility placement.	CONTRACTORs self report
Health and Welfare	Quarterly	Total number of HCBS beneficiaries vs. the total number of HCBS beneficiaries that transfer to a nursing facility.	Percentage of HCBS beneficiaries that transfer to a nursing facility.	CONTRACTORs self report
Health and Welfare	Annually	Average number of days of nursing facility care provided to clients who were previously enrolled in HCBS services through the CONTRACTOR.	Average nursing facility length of stay for clients who had previously received HCBS services through the CONTRACTOR.	CONTRACTORs self report
Health and Welfare	Quarterly	Total sample number of beneficiaries that meet nursing facility level of care criteria vs. number of sample beneficiaries that are cared for in the community.	Nursing facility diversion rate	To be specified by State
Health and Welfare (LD)	Annually	Total number of nursing facility days of care vs. total number of nursing facility eligible beneficiaries.	Average nursing facility utilization for eligible beneficiaries (avg. NF days of care).	To be specified by State
Customer Satisfaction	Annually	Customer Satisfaction Survey	5% improvement in Member satisfaction rate among elderly Members	To be specified by State
Health and Welfare (LD)	Annually	Percent of total nursing facility resident days provided in homes designated as Person-Centered Care Homes by KDOA's PEAK program.	Statewide percent of total from the previous year	To be specified by State

Appendix 12- Pay for Performance Measure Specifications

The following figures delineate the methodology and specifications for the behavioral health, HCBS, and long term care P4P measures for years two (2) and three (3). The CONTRACTOR(S) shall follow all the specified requirements in measuring and reporting on these P4P measures.

Figure 1: Employment	
MH_1a and HCBS_1a: Gained Competitive Employment	
Item	**Details**
The number and percent of members, diagnosed with SPMI or experiencing SED, who gained competitive employment.	
Numerator:	The number of Members attaining part-time or full-time competitive employment.
Denominator:	The number of Members that were: • Enrolled for services at a CMHC. • Medicaid or CHIP eligible and continuously enrolled for 11 of 12 months during the measurement period. • Ages 18 to 65. • Received MH Services. • Diagnosed with SPMI, transition age youth experiencing SED, or receiving services through the PRTF CBA. • Not employed at the start of the measurement period.
Data Source	Enrollment and employment information, including an annual baseline count, will be developed from data reported by the CMHCs through AIMS.
Benchmark/Goal	Competitive employment will exceed the benchmark based on existing Medicaid data, as established by the State.
Description of Monitoring Process	Enrollment and employment information, including an annual baseline count, will be developed from data reported by the CMHCs through AIMS. A Member who is competitively employed is one who is engaged in part-time (at least 5 hours per week) or roughly full-time (at least 30 hours per week), paid employment in the community. For part-time employment, less than 30 hours per week, a job coach may be present less than 33% of the work time. The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual

The number and percent of Members, receiving waiver services through CSS, who gained competitive employment.	
Numerator:	The number of Members attaining part-time or full-time competitive employment.
Denominator:	The number of Members that were: • Medicaid or CHIP eligible and continuously enrolled for 11 of 12 months during the measurement period. • HCBS MRDD, PD or TBI Waiver Member, or on one of the waiver waiting lists. • Not employed at the start of the measurement period and want to gain employment. • Ages 18 to 65.
Data Source	Targeted case managers are surveyed and report information for their current case load, regarding Members' desire to be employed and current employment status. The survey is conducted electronically using Zoomerang, a web-based survey tool. Data is downloaded in MS Excel format for analysis and reporting.
Benchmark/Goal	Competitive employment will exceed the benchmark based on existing Medicaid data, as established by the State.
Description of Monitoring Process	A Member who is competitively employed is engaged in work part-time (at least 5 hours per week and less than 30) or full-time (30 hours per week or more). The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual

MH_1b and HCBS_1b: Maintained Competitive Employment	
Item	**Details**
The number and percent of Members, diagnosed with SPMI or experiencing SED, who maintained competitive employment.	
Numerator:	The number of Members maintaining part-time or full-time competitive employment for a period of at least 3 consecutive months.
Denominator:	The number of Members that were: • Enrolled for services at a CMHC. • Medicaid or CHIP eligible and continuously enrolled for 11 of 12 months during the measurement period. • Ages 18 to 65. • Received MH Services. • Diagnosed with SPMI, transition age youth experiencing SED, or receiving services through the PRTF CBA. • Not employed at the start of the measurement period. • That gained employment during the measurement period.
Benchmark/Goal	Competitive employment will exceed the benchmark based on existing Medicaid data, as established by the State. Specifically, during the first year of this contract, 200 people with SPMI who are receiving CSS at a CMHC will gain and maintain for at least 3 consecutive months, part-time or full-time employment.
Data Source	Enrollment and employment information, including an annual baseline count, will be developed from data reported by the CMHCs through AIMS.
Description of Monitoring Process	Enrollment and employment information, including an annual baseline count, will be developed from data reported by the CMHCs through AIMS. A Member who is competitively employed is one who is engaged in part-time (at least 5 hours per week) or roughly full-time (at least 30 hours per week), paid employment in the community. For part-time employment, less than 30 hours per week, a job coach may be present less than 33% of the work time. The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual

The number and percent of Members, receiving waiver services through CSS, who maintained competitive employment.	
Numerator:	The number of Members maintaining part-time or full-time competitive employment for a period of 90 or more consecutive days.
Denominator:	The number of Members that were: • Medicaid or CHIP eligible and continuously enrolled for 11 of 12 months during the measurement period. • HCBS MRDD, PD or TBI Waiver Member, or on one of the waiver waiting lists. • Not employed at the start of the measurement period and want to gain employment. • That gained employment during the measurement period. • Ages 18 to 65.
Data Source	Targeted case managers are surveyed and report information for their current case load, regarding Members' desire to be employed and current employment status. The survey is conducted electronically using Zoomerang, a web-based survey tool. Data is downloaded in MS Excel format for analysis and reporting.
Benchmark/Goal	Competitive employment will exceed the benchmark based on existing Medicaid data, as established by the State. Specifically, during the first year of this contract, 500 people, either receiving or waiting for services, will gain and maintain for at least 90 days of part-time or full-time competitive employment.
Description of Monitoring Process	A Member who is competitively employed is engaged in work part-time (at least 5 hours per week and less than 30) or full-time (30 hours per week or more). The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual

Figure 2: NOMS	
Substance Use Disorder NOMS	
NOMS_SUD_1: Living Arrangements	
Item	**Details**
The number and percent of Members, receiving SUD services, whose living arrangements improved.	
Numerator:	The number of episodes of care in which: • Members were living independently at the time of admission and maintained independent living status at discharge, or Members reported their living arrangements improved between admission and discharge.
Denominator:	The number of episodes of care for: • Members who were Medicaid or CHIP eligible. • Members discharged from SUD services during the measurement period. • Members whose living arrangements were collected and known at time of admission and discharge.
Data Source	Admission and discharge data are collected in KCPC.
Benchmark/Goal	The CONTRACTOR will meet or exceed the benchmark based on existing Medicaid data, as established by the State. The most recent 3 years of annual aggregated data will be used to determine the benchmark for this measure.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual
NOMS_SUD_2: Criminal Justice Involvement	
Item	**Details**
The number and percent of Members, receiving SUD services, whose criminal justice involvement improved.	
Numerator:	The number of episodes of care in which: • Members reported no arrests in the prior 30 days at both admission and discharge, or at discharge fewer arrests were reported than when admitted.

Denominator:	The number of episodes of care for: • Members who were Medicaid or CHIP eligible. • Members discharged from SUD services during the measurement period. • Members whose criminal justice involvements were collected and known at time of admission and discharge.
Data Source	Admission and discharge data are collected in KCPC.
Benchmark/Goal	The CONTRACTOR will meet or exceed the benchmark based on existing Medicaid data, as established by the State. The most recent 3 years of annual aggregated data will be used to determine the benchmark for this measure.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual

NOMS_SUD_3: Drug and/or Alcohol Use	
Item	**Details**
The number and percent of members, receiving SUD services, whose drug and/or alcohol use decreased.	
Numerator:	The number of episodes of care in which: • Members reported for the prior 30 days, no use of their primary substance at discharge, or decreased use of their primary substance between admission and discharge.
Denominator:	The number of episodes of care for: • Members who were Medicaid or CHIP eligible. • Members discharged from SUD services during the measurement period. • Members whose primary substance uses were collected and known at the time of admission and discharge.
Data Source	Admission and discharge data are collected in KCPC.
Benchmark/Goal	The CONTRACTOR will meet or exceed the benchmark based on existing Medicaid data, as established by the State. The most recent 3 years of annual aggregated data will be used to determine the benchmark for this measure.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual
NOMS_SUD_4: Attendance of Self-Help Meetings	
Item	**Details**
The number and percent of members, receiving SUD services, whose attendance of self-help meetings increased.	
Numerator:	The number of episodes of care in which: • Members reported for the prior 30 days, increased attendance of self-help meetings between admission and discharge.
Denominator:	The number of episodes of care for: • Members who were Medicaid or CHIP eligible. • Members discharged from SUD services during the measurement period. • Members whose attendance of self-help meetings were collected and known at time of admission and discharge.

Data Source	Admission and discharge data are collected in KCPC.
Benchmark/Goal	The CONTRACTOR will meet or exceed the benchmark based on existing Medicaid data, as established by the State. The most recent 3 years of annual aggregated data will be used to determine the benchmark for this measure.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual

NOMS_SUD_5: Employment Status	
Item	**Details**
The number and percent of Members, receiving SUD services, whose employment status increased.	
Numerator:	The number of episodes of care in which: • Members reported for the prior 30 days, they maintained full time employment at both admission and discharge, or they improved their employment status between admission and discharge.
Denominator:	The number of episodes of care for: • Members who were Medicaid or CHIP eligible. • Members discharged from SUD services during the measurement period. • Members whose employment statuses were collected and known at time of admission and discharge.
Data Source	Admission and discharge data are collected in KCPC.
Benchmark/Goal	The CONTRACTOR will meet or exceed the benchmark based on existing Medicaid data, as established by the State. The most recent 3 years of annual aggregated data will be used to determine the benchmark for this measure.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual
Substance Use Disorder NOMS Compliance Standard	
To be considered compliant, 4 of 5 SUD specific indicators must meet or exceed the benchmarks. The five SUD measures evaluated include: • NOMS_SUD_1: Living Arrangements. • NOMS_SUD_2: Number of Arrests. • NOMS_SUD_3: Drug and Alcohol Use. • NOMS_SUD_4: Attendance at Self-Help Meetings. • NOMS_SUD_5: Employment Status.	

Mental Health NOMS	
NOMS_MH_1: Adult Access to Services	
Item	**Details**
The number and percent of adults with SPMI who had increased access to services.	
Numerator:	Number of adults with SPMI that received services at a CMHC.
Denominator:	Total estimated prevalence of Medicaid funded adults with SPMI.
Data Source	Enrollment and pay source information provided by the CMHCs through AIMS; Medicaid Managed Care claims history, demographic data and prevalence rates based on accepted formulas.
Benchmark/Goal	The CONTRACTOR will meet or exceed the benchmark based on existing Medicaid data, as established by the State. Aggregated data will be used to determine the benchmark for this measure.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual

NOMS_MH_2: Youth Access to Services	
Item	**Details**
The number and percent of youth experiencing SED who had increased access to services.	
Numerator:	Number of youth experiencing SED that received services at a CMHC.
Denominator:	Total estimated prevalence of Medicaid funded youth experiencing SED.
Data Source	Enrollment and pay source information provided by the CMHCs through AIMS; Medicaid Managed Care claims history, demographic data and prevalence rates based on accepted formulas.
Benchmark/Goal	The CONTRACTOR will meet or exceed the benchmark based on existing Medicaid data, as established by the State. Aggregated data will be used to determine the benchmark for this measure.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual
NOMS_MH_3: Homeless SPMI	
Item	**Details**
The number and percent of adults with SPMI who were homeless.	
Numerator:	The number of adults with SPMI receiving services at a CMHC who are homeless
Denominator:	The number of adults with SPMI receiving services at a CMHC.
Data Source	Enrollment and pay source information provided by the CMHCs through AIMS; Medicaid Managed Care claims history.
Benchmark/Goals	The CONTRACTOR will meet or exceed the benchmark based on existing Medicaid data, as established by the State. Aggregated data will be used to determine the benchmark for this measure.
Description of Monitoring Process	An accurate count of homeless people is difficult to obtain. Identification of homeless people who are in need of mental health services is also difficult. Those individuals who are precariously

	housed are not considered homeless for purposes of this measure. The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual

NOMS_MH_4: School Attendance	
Item	**Details**
The number and percent of youth experiencing SED who are attending school regularly.	
Numerator:	The number of youth attending school regularly.
Denominator:	The number of youth, ages 5 to 18, experiencing SED and receiving services through a CMHC**.**
Data Source	Enrollment and pay source information provided by the CMHCs through AIMS; Medicaid Managed Care claims history.
Benchmark/Goal	The CONTRACTOR will meet or exceed the benchmark based on existing Medicaid data, as established by the State. Aggregated data will be used to determine the benchmark for this measure.
Description of Monitoring Process	Regular school attendance is defined as youth with no more than 6 unexcused absences reported in the measurement period. The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual
NOMS_MH_5: Youth Living in a Family Home	
Item	**Details**
The number and percent of youth living in a family home.	
Numerator:	The number of youth living in a family home.
Denominator:	The number of youth receiving MH services through a CMHC**.**
Data Source	Enrollment and pay source information provided by the CMHCs through AIMS; Medicaid Managed Care claims history.
Benchmark/Goal	The CONTRACTOR will meet or exceed the benchmark based on existing Medicaid data, as established by the State. Aggregated data will be used to determine the benchmark for this measure.

Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report
Monitoring Frequency	Annual
Mental Health NOMS Compliance Standard	
To be considered compliant, 4 of 5 MH NOMS indicators must meet or exceed the benchmarks. The 5 MH measures evaluated include: • NOMS_MH_1: Adult Access to Services. • NOMS_MH_2: Youth Access to Services. • NOMS_MH_3: Homeless SPMI. • NOMS_MH_4: Youth School Attendance. • NOMS_MH_5: Youth Living in a Family Home.	

Figure 3	
Utilization of Inpatient Services	
Item	**Details**
The number and percent of members utilizing inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services.	
Numerator:	The number of Members utilizing inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services.
Denominator:	The number of Members that were Medicaid or CHIP eligible and continuously enrolled for 11 of 12 months during the measurement period.
Data Source	MMIS and the State Hospital database will be used.
Benchmark/Goal	The CONTRACTOR will exceed the benchmark based on existing Medicaid data, as established by the State. Aggregated data will be used to determine the benchmark for this measure. Specifically, the rate will decrease by a targeted percentage.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual

Figure 4	
Life Expectancy	
Item	**Details**
Life expectancy for people with disabilities. *Note: Because life expectancy is not stated as a rate or percentage, a numerator and denominator statement will not be included for this measure.*	
Data source	This measure will be developed based on standard actuarial models. Since the population with disabilities is a relatively small group, it is likely mortality data for the broader Medicaid population will be mathematically adjusted to reflect the observed differences for this subgroup.
Benchmark/Goal	The benchmark will be established based on the first year of data collection and improvement goals identified by the State.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual

Figure 5	
Integration of Health Care	
Item	**Details**
The level of integration of physical, behavioral, long term care and HCBS.	
Numerator:	The number of Members whose case manager and/or other primary providers reported, through the survey tool, a moderate or high level of clinical integration of care.
Denominator:	The number of Members that were: • Medicaid or CHIP eligible. • Received HCBS waiver services, specialized rehabilitation MH services, or discharged from SUD services during the measurement period.
Data Sources	The eligible Member population will be identified using Medicaid eligibility data and CONTRACTOR service claims. The level of service integration and coordination will be measured through administration of a survey to clinical case managers and/or other service providers.
Benchmark/Goal	The rate of integration will increase. The benchmark will be established based on the first year of data collection and improvement goals identified by the State.
Description of Monitoring Process	A survey tool will be developed to measure the level of clinical integration of care, based on adaptation of an existing tool, such as the Health Systems Integration Study (HSIS). The adapted survey tool will be tested for validity and reliability, and then fielded on an annual basis. The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual

Figure 6	
NF_1: Claim Denials	
Item	**Details**
Percentage of Medicaid NF claims denied by the CONTRACTOR.	
Numerator:	The number of NF claims denied by the CONTRACTOR.
Denominator:	The number of timely filed NF claims processed by the CONTRACTOR during the measurement period.
Data Source	CONTRACTOR claims data.
Benchmark/Goal	The CONTRACTOR will meet or exceed the benchmark based on existing Medicaid data, as established by the State. Aggregated data will be used to determine the benchmark for this measure.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	KDOA will monitor the report.
Monitoring Frequency	Quarterly

Figure 7	
NF_2: Fall Risk Management	
Item	**Details**
The percentage of members who had a fall, had problems with balance and walking, or were identified as at risk for a fall during the measurement period, who were seen by a practitioner during the measurement period and who received fall risk intervention from their current practitioner.	
Numerator:	The number of members who received a fall risk intervention from their current practitioner.
Denominator:	The number of Medicaid eligible Members who: • Had a fall, had problems with balance and walking, or were identified as at risk for a fall during the measurement period. • Were seen by a practitioner during the measurement period.
Data Source	Medicaid Claims, Uniform Assessment Instrument information and/or the MDS database will be used to identify the eligible population. A survey tool, similar to the Medicare Health Outcomes Survey, will be used to collect data regarding fall risk interventions.
Benchmark/Goal	The benchmark will be established based on the first year of data collection and improvement goals identified by the State.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	KDOA will monitor the report.
Monitoring Frequency	Annual

Figure 8	
NF_3: Hospital Admission after NF Discharge	
Item	**Details**
The percentage of Members discharged from a NF who had a hospital admission within 30 days.	
Numerator:	The number of Members that have an acute care hospital admission within 30 days of NF discharge.
Denominator:	The number of Members who were discharged from a NF during the measurement period. Excludes: • Hospital-based rehabilitation services. • Excludes members admitted to the hospital on the NF discharge date. • NF discharges for death. • Acute inpatient stays for pregnancy.
Data Sources	NF discharge data is collected through MDS. Hospital admission data will be identified through CONTRACTOR claims data.
Benchmark/Goal	The CONTRACTOR will exceed the benchmark based on existing Medicaid data, as established by the State. Aggregated data will be used to determine the benchmark for this measure.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	KDOA will monitor the report.
Monitoring Frequency	Quarterly

Figure 9	
NF_4: NF Days of Care	
Item	**Details**
NF utilization for eligible beneficiaries. *Note: This measure will be stated as the rate of NF days per eligible Member, rather than as a percentage.*	
Numerator:	The number of nursing home days of care during the measurement period for those Members meeting the eligibility criteria.
Denominator:	Medicaid eligible individuals who received a functional level of care (LOC) assessment, and who met the criteria indicating NF LOC was appropriate, including: • FE Waiver participants. • NF residents. • Other individuals, regardless of services received, who were assessed.
Data Sources	LOC assessment data will be used to identify eligible Members, and NF claims will be used to identify the total number of NF days used during the measurement period.
Benchmark/Goal	The CONTRACTOR will exceed the benchmark based on existing Medicaid data, as established by the State. Aggregated data will be used to determine the benchmark for this measure.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	KDOA will monitor the report.
Monitoring Frequency	Annually

Figure 10	
NF_5: Resident Days in PEAK Homes	
Item	**Details**
Percentage of NH days paid to Promoting Excellent Alternatives in Kansas (PEAK)-certified Person-Centered Care Homes.	
Numerator:	The total number of nursing home days, provided in nursing facilities designated as Person-Centered Care Homes through the PEAK program, paid during the measurement period.
Denominator:	The total number of nursing home days paid during the measurement period.
Data Sources	PEAK Program data will be used to identify PEAK designated homes, and claims will be used to identify the total number of NF days reported by provider for the measurement period.
Benchmark/Goal	The CONTRACTOR will exceed the benchmark based on existing Medicaid data, as established by the State. Aggregated data will be used to determine the benchmark for this measure.
Description of Monitoring Process	Nursing facilities that meet certain core competencies can apply for recognition as a Person-Centered Care Home provided they also obtain at least a 3-star rating on the survey section of the nursing facility report card. The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	KDOA will monitor the report.
Monitoring Frequency	Annually